

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

28486

**1. PLACE OF DEATH**

County.....  
Township.....  
City.....

Registration District No. **791**  
**1003**  
Primary Registration District No. **7208 Flora Place**

File No.....  
Registered No. **8388**  
St..... Ward.....

**2. FULL NAME**

(a) Residence. No. **Patrick St John** St. **17** Ward.....  
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Married**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Nanorah Carey**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Sept 8-1858**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hrs. or .....min.  
**71 11 14**

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work **Retired Const or Builder**  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer **Self**

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY) **Ireland**

**10. NAME OF FATHER**

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY) **Ireland**

**12. MAIDEN NAME OF MOTHER**

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY) **Ireland**

**14.**

INFORMANT **Dr Thos C St John**  
(Address) **4208 7<sup>th</sup> Coz Place**

**15.**

**AUG 23 1930**  
FILED **19** REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Aug 22 1930**

17. I HEREBY CERTIFY, That I attended deceased from **Aug 22**, 19....., to **Aug 22**, 19....., that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at **11 am**.....m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

**Preliminary Embolism**  
**1211**  
**1129**  
..... (duration) ..... yrs..... mos..... ds.  
CONTRIBUTORY **Chronic Deg. Nephritis**  
(SECONDARY)  
**Arteriosclerosis**..... (duration) ..... yrs..... mos..... ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY? **Yes**

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) **Chas. L. Keen**..... M. D.

, 19 (Address) **Metropolitan Bldg**

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**19. PLACE OF BURIAL, CREMATION, OR REMOVAL**

**DATE OF BURIAL**

**Galvay Cem**

**Aug 25 1930**

**20. UNDERTAKER**

**ADDRESS**

**Thos J. Finnan**

**51, 95  
Frank**

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

