

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

Do not use this space.
28612

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City **St. Louis, Mo.** (No. **6119** **Alabama Ave.**, St. Ward)

File No.
 Registered No. **8520**

2. FULL NAME Mary Flynn

(a) Residence. No. **6119 Alabama Ave.**, St. Ward. (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Widowed.</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Unknown.</u>		
7. AGE YEARS <u>About 78</u>	MONTHS	DAYS
If LESS than 1 day, hrs. or min.		
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>At Home</u> (c) Name of employer		

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

PARENTS	10. NAME OF FATHER <u>John Laffey</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Ireland</u>
	12. MAIDEN NAME OF MOTHER <u>Unknown</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Ireland</u>

14. INFORMANT Julia Sobradi
 (Address) 6119 Virginia

15. AUG 28 1930 FILED Mary O. Starbuck REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug. 27, 1930

17. I HEREBY CERTIFY, That I attended deceased from March 12, 1930 to August 27, 1930 that I last saw h. l. alive on August 26, 1930, and that death occurred, on the date stated above, at 7:00 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of stomach
 (duration) 2 yrs. mos. ds.
 CONTRIBUTORY Arteriosclerosis
 (SECONDARY) (duration) chronic yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? No DATE OF
 WAS THERE AN AUTOPSY? No
 WHAT TEST CONFIRMED DIAGNOSIS? Stomach
 (Signed) W. J. Phillips, M. D.
8/27, 1930 (Address) 7702 Broadway

*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 <u>Calvary Cemetery</u>	DATE OF BURIAL <u>Aug. 29 1930</u>
20. UNDERTAKER <u>Southern</u>	ADDRESS <u>6320 S. Grand.</u>

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.

