

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

Do not use this space.

34110

File No. _____
Registered No. **9427**
St. _____ Ward _____

1. PLACE OF DEATH

County _____ Registration District No. **701**
Township _____ Primary Registration District No. **1003**
City **St. Louis** (No. **Seaconess Hospital**)

2. FULL NAME

Mary A Tiffin
(a) Residence. No. **21 Tiffin Ave Ferguson** St. **no 4** Ward. **Ferguson Mo**
(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 Female	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 Gabriel Tiffin		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 18 1855		
7. AGE YEARS 75	MONTHS 3	DAYS 26
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work Housewife (b) General nature of industry, business, or establishment in which employed (or employer). (c) Name of employer		

9. BIRTHPLACE (CITY OR TOWN). **St Louis**
(STATE OR COUNTRY) **MO**

PARENTS	10. NAME OF FATHER Martin Menton
	11. BIRTHPLACE OF FATHER (CITY OR TOWN). (STATE OR COUNTRY) Ireland
	12. MAIDEN NAME OF MOTHER Kath Leon
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN). (STATE OR COUNTRY) Ireland

14. INFORMANT **Kath Tiffin**
(Address) **21 Tiffin Ave Ferguson**

15. FILED **19** **1930** **REGISTRAR**

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Oct 1 1930**
17. I HEREBY CERTIFY, That I attended deceased from **July 1 1930** to **Oct 1 1930** that I last saw her alive on **Apr 30 1930** and that death occurred, on the date stated above, at **12:30 a.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Pyemia
4LB 444
(duration) yrs. mos. ds.

CONTRIBUTORY **Atherosclerosis**
(SECONDARY) (duration) yrs. mos. ds.

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

1 DID AN OPERATION PRECEDE DEATH? **Yes** DATE OF **Apr 24/30**

2 WAS THERE AN AUTOPSY? **No**
WHAT TEST CONFIRMED DIAGNOSIS
(Signed) **L. H. Thompson** M. D.
171, 1930 (Address) **626 Hampton Hwy**

*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 **Salvum Cem** DATE OF BURIAL **Oct 7 1930**

20. UNDERTAKER **Shos & Tiffin** ADDRESS **151 95 Grand**

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.

1200
Merry in 1811