

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

Do not use this space.

34649

1. PLACE OF DEATH

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

Registration District No.
Primary Registration District No. **1003**
(No. **4413** Delmar)

File No.
Registered No. **10032**
St. Ward)

2. FULL NAME

Mollie A. Fagan

(a) Residence No. **4413 Delmar** St., **19** Ward. (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. da.

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 **Raymond Fagan**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **July 12, 1892**

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
38	3	8	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work **Housewife** 48 hrs
(b) General nature of industry, business, or establishment in which employed (or employer) 57
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **Edwardsville**
(STATE OR COUNTRY) **Delaware**

10. NAME OF FATHER **unknown**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) **unknown**
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER **unknown**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **unknown**
(STATE OR COUNTRY)

14. INFORMANT **Raymond Fagan**
(Address) **4413 Delmar**

15. FILED **22 1930** **Map G. Starikoff**
REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Oct. 20 1930**

17. I HEREBY CERTIFY, That I attended deceased from **July 20 - 1930 to Oct. 20 1930**
that I last saw h. or alive on **Oct. 19, 1930** and that death occurred, on the date stated above, at **7:30 a.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Carcinoma of Uterus
(Properable)

From History (duration) **1** yrs. mos. da.
CONTRIBUTORY (SECONDARY) **Metastasis of Rectum + Pelvis**
(duration) **1** yrs. mos. da.

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

0 DID AN OPERATION PRECEDE DEATH? **NO** DATE OF OPERATION **NO DATE**
Radium 325 used at City Hospital
WAS THERE AN AUTOPSY? **NO**
WHAT TEST CONFIRMED DIAGNOSIS? **Pelvic examination at City Hospital**
(Signed) **A. J. Alendrock**, M. D.

10.21.1930 (Address) **1041 Measurin Pl**

*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 **Calvary Cemetery**
DATE OF BURIAL **10/23 1930**

20. UNDERTAKER **Jno. P. Collins**
ADDRESS **928 Northrup**

Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified.

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