

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

Do not use this space.

34797

**1. PLACE OF DEATH**

County..... Registration District No..... **791**  
 Township..... Primary Registration District No..... **1003**  
 City St. Louis, Mo. (No. 1320 S. 6th Street St. \_\_\_\_\_ Ward \_\_\_\_\_)  
 File No. **10189**  
 Registered No. \_\_\_\_\_

**2. FULL NAME** Mary Humphries  
 (a) Residence. No. 1320 S. 6th Street St. W 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** Female **4. COLOR OR RACE** White **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** (write the word) Widow

**5A. IF MARRIED, WIDOWED, OR DIVORCED**  
 HUSBAND OF (OR) WIFE OF Benjamin Humphries

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)** January 5th, 1869

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1
				day, .....hrs. or .....min.
	62	9	21	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work At Home  
 (b) General nature of industry, business, or establishment in which employed (or employer) Housework  
 (c) Name of employer \_\_\_\_\_

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

(STATE OR COUNTRY) New York

**10. NAME OF FATHER** Pat Short

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

**12. MAIDEN NAME OF MOTHER** Unknown

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

**14. INFORMANT** Mrs. L. Hayes  
 (Address) 1320 S. 6th Street

**15. FILED** \_\_\_\_\_ 1927 May C. Standen REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** October 26th, 30.

**17. I HEREBY CERTIFY**, That I attended deceased from Oct. 3, 1920, to Oct 25, 1920, that I last saw h.s. alive on Oct 25, 1920, and that death occurred, on the date stated above, at 10:35 A. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Acute Aberrant hepatitis

**CONTRIBUTORY (SECONDARY)** \_\_\_\_\_ (duration) yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED** \_\_\_\_\_ (duration) yrs. mos. ds.

IF NOT AT PLACE OF DEATH \_\_\_\_\_

**19. DID AN OPERATION PRECEDE DEATH?** no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?  
 (Signed) Francis Dawson M. D.

1927, 1930 (Address) 1319 So. Belway

\*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 **DATE OF BURIAL** Oct. 28, 1930.

**20. UNDERTAKER** Wacker-Heldrich **ADDRESS** 2331 S. Brdwy.

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.

