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.

CERTIFICATE OF DEATH

1. PLACE OF DEATH
County St. Louis
Township Carondelet
City Koch (No. Koch Hosp. St. Ward)

Registration District No. 1123
Primary Registration District No. 6248 B,

File No. 40652
Registered No. 414

JAN 22 1931

2. FULL NAME HEFFERN EDW

(a) Residence. No. 2751 Shenandoah St., Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 2 yrs. 7 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF
Single

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 30 1876

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
54	44	6	19	

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

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

PARENTS
10. NAME OF FATHER Patrick Heffern
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ireland
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Ellen McMahan
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ireland
(STATE OR COUNTRY)

14. INFORMANT Koch Hospital Records
(Address) Koch Mo

15. Filed Dec 30 1930 L. C. Obrock REGISTRAR

3

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 19 1930

17. I HEREBY CERTIFY, That I attended deceased from April 25, 1928 to Dec. 19 1930 that I last saw him alive on Dec. 19 1930, and that death occurred, on the date stated above, at 9:30 A.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary Tuberculosis
234
25
31 About (duration) 3 yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Gastro-Intestinal Tbc
About (duration) 2 yrs. mos. ds.

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

19. DID AN OPERATION PRECEDE DEATH? No. DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? X Ray & Sputum
(Signed) Royal A. Weir, M. D.
12/19/30 (Address) Koch Hosp.

*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 St. Peter Pond — DATE OF BURIAL Dec 22 1930

20. UNDERTAKER John P. Collins — ADDRESS 912 N. Grand

John P. Collins 912 N. Grand

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No.....

City..... (No....., ...St. .....Ward)

2. FULL NAME.....

(a) Residence. No.....St., ...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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

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

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN).....
(STATE OR COUNTY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTY)

14.
INFORMANT.....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

..... (duration) .....yrs.....mos.....ds.

CONTRIBUTORY.....
(SECONDARY)

..... (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? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed)..... ....., M. D.

, 19 (Address)

*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 19
20. UNDERTAKER	ADDRESS

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.