

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

7104

File No. _____
Registered No. **1389**
St. _____ Ward _____

1. PLACE OF DEATH

County _____ Registration District No. **791**
Township _____ Primary Registration District No. **1003**
City **St. Louis** (No. **1806** **Bacon St.**)

2. FULL NAME *Elizabeth Firl*

(a) Residence. No. **1806 Bacon** St. **11** 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)** *Widowed*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Aug. 21-1854*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
76 5 12

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).

(c) Name of employer.

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *England*

10. NAME OF FATHER *Robert Cochran*

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

12. MAIDEN NAME OF MOTHER *Mary M. Firl*

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

14. INFORMANT *Ferd Firl*
(Address) *1806 Bacon St*

15. FILED *FEB - 1 1931*
M. C. Stanley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Feb 2 1931*

17. I HEREBY CERTIFY, That I attended deceased from *January 10*, 19*31*, to *February 2*, 19*31*, that I last saw her alive on *Feb 2*, 19*31* and that death occurred, on the date stated above, at *4:15* p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Apoplexy

970 (duration) _____ yrs. _____ mos. *10* ds.

CONTRIBUTORY (SECONDARY) *Stimpigia Apoplectica*

(duration) _____ yrs. _____ mos. *10* ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

20. WAS THERE AN AUTOPSY? *(1)*

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) *M. J. Grogan*, M. D.

, 19 (Address) *1806 Bacon St*

*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** *Feb 5 1931*

20. UNDERTAKER *Cullinan Bros* **ADDRESS** *1710 N. Grand St*

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.

Grand St. Louis