

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

Do not use this space.

7376

1. PLACE OF DEATH

County.....

Registration District No.....

Township.....

Primary Registration District No.....

City.....

St. Louis Mo., No. 1004 Allen Av.

791
1003

File No.....

1692

Registered No.....

St.....

Ward.....

2. FULL NAME

(a) Residence No. *1004 Allen Av.* J. St. *23* 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. da.

How long in U.S., if of foreign birth? yrs. mos. da.

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

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

June 30-1883

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

47

7

8

8. OCCUPATION OF DECEASED

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

Butcher 159

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

1

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Massouri 1

10. NAME OF FATHER

Thomas Cauley

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ireland 15

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ireland

14.

INFORMANT (Address)

Mrs John Bartoach 1004 Allen Av.

15.

FEB 10 1931 FILED

May C. Harkley

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

February 8 1931

17. *No Physician in attendance*
HEREBY CERTIFY, That I attended deceased from

..... 19....., to 19....., and that I last saw h..... alive on 19....., death occurred, on the date stated above, at *11:30 A*..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

chronic interstitial 131 nephritis

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH.....

DATE OF.....

WAS THERE AN AUTOPSY? *yes*

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *J. P. Sevier*

2/9 19 31 (Address) *Deputy Coroner*

*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

Calvary Cemetery

Feb. 11 1931

20. UNDERTAKER

ADDRESS

E. J. Seimer

3125 Lafayette Av.

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.

MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS 1931 PERM. NO. 1003

