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.

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

Do not use this space.

12082

1. PLACE OF DEATH

County ..... Registration District No. 791 ..... File No. 3338

Township ..... Primary Registration District No. 1009 ..... Registered No. 3338

City St Louis (No. 4378 Maryland St. ..... Ward)

2. FULL NAME Nellie A Carney

(a) Residence. No. ..... St., 19 Ward. ..... (If nonresident, give city or town and State)
(Usual place of abode)

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)
Female	White	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 12 1860

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	71	3	3	

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) Ohio 2

PARENTS

10. NAME OF FATHER Thomas Carney

11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Ireland 15

12. MAIDEN NAME OF MOTHER Mary Ford

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

14. INFORMANT Mary B Carney
(Address) 4378 Maryland

15. FILED ..... 19 ..... [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mch 15 1931

17. I HEREBY CERTIFY, That I attended deceased from 11th March, 1931 to March 15, 1931 that I last saw her alive on 3/15, 19..., and that death occurred, on the date stated above, at 7 40 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Apoplexy Cerebral
Hemorrhage
(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (SECONDARY) None
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED? 82A
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) Dr Joseph Schafer M. D.
3/16, 1931 (Address) 333 University Club Bldg

*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	Mch 18 1931
20. UNDERTAKER	ADDRESS 4415
Harrigan & Sheahan	Washington

Dr [illegible]
Univ Club.
[illegible] 9130