

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

Do not use this space.

16150

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1008**

City, **St. Louis** (No. **City Hosp.**)

File No.....

Registered No. **4627**

St.

Ward)

2. FULL NAME

(a) Residence No. **3140 Evans** 21 Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred **35** yrs. mos. ds.

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

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

Thomas Clark

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

July 20th - 1860

7. AGE

YEARS *70*

MONTHS *8*

DAYS *27*

IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

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

Housework

(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)

Ireland

10. NAME OF FATHER

Pat Caheny

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ireland

12. MAIDEN NAME OF MOTHER

Bridgett Kelly

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ireland

14.

INFORMANT

(Address)

FILED

19

*Hospital information
Pat Caheny
City Hospital*

*Pat Caheny
City Hospital*

FILED

19

*Pat Caheny
City Hospital*

REGISTRAR

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

April 16th 1931

17.

I HEREBY CERTIFY, That I attended deceased from

Mar. 18th 1931 to April 16th 1931

that I last saw her alive on *April 16th 1931*, and that

death occurred, on the date stated above, at *11:00 a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

*103 Hypostatic pneumonia
131 Chronic myocarditis
135 Chronic nephritis
1115*

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

Senile Dementia

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? *no* DATE OF

WAS THERE AN AUTOPSY? *refused*

WHAT TEST CONFIRMED DIAGNOSIS?

Clinical & laboratory

(Signed)

W. Scherman M. D.

(Address)

City Hospital

*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

4/18 1931

20. UNDERTAKER

ADDRESS

Arthur J. Donnelly Trust Co. 2039 Wash 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.

