

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

Do not use this space.

19905

1. PLACE OF DEATH

County.....
Township.....
City St. Louis Mo. (No.)

Registration District No. 791
1003
Primary Registration District No.

File No.
Registered No. 5930
St. Ward)

2. FULL NAME

Margaret Bruce
(a) Residence. No. 4704 Morganford Rd. 13 Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs. + mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar. 22, 1879

7. AGE	YEARS	MONTHS	DAYS	IF LESS' than 1 day,hra. ormin.
	62	2	 	

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) County Mayo, Ireland
(STATE OR COUNTRY)

10. NAME OF FATHER Michael Clarke, County Mayo, Ireland

11. BIRTHPLACE OF FATHER (CITY OR TOWN) County Mayo, Ireland
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Predget Jennings, County Mayo, Ireland

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

14. INFORMANT Dr. Mullinan
(Address) 5300 Arsenal

15. FILED MAY 25 1931 May Osterberg REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-22 1931

17. I HEREBY CERTIFY, That I attended deceased from May 11 1931 to May 22 1931.
that I last saw her alive on May 22, 1931, and that death occurred, on the date stated above, at 9:58 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

gza
Cerebral Hemorrhage, Apoplexy
(duration) 12 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) gzw
(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? no

WHAT TEST CONFIRMED DIAGNOSIS clinical
(Signed) Dr. Mullinan, M.D.

5-22, 1931 (Address) 5300 Arsenal

*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 DATE OF BURIAL 5/26 1931

20. UNDERTAKER John Mullin, Dr. 728 Grand 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.

