

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

Do not use this space.
19929

1. PLACE OF DEATH

County.....

Registration District No. **791**
1008

Township.....

Primary Registration District No.

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

File No.

Registered No. **5958**

St. Ward)

2. FULL NAME

(a) Residence. No. **20793** **Mary Holcombe**
(Usual place of abode) **Majestic Hotel 253** Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred **4** 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)

married

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

Geo. Holcombe

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

Unk.

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

abt. 52

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) **Mass. 2**

10. NAME OF FATHER

Patrick Walsh

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) **Mass.**

12. MAIDEN NAME OF MOTHER

Unk.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) **Unk.**

14. Hospital Information

INFORMANT

(Address)

Chry Hospital

15. FILED

FILED

Marie Starling
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

21
16. DATE OF DEATH (MONTH, DAY AND YEAR) **May 5th 1931**

17. I HEREBY CERTIFY, That I attended deceased from Feb. 28th 1931 to May 5th 1931, and that I last saw her alive on May 5th 1931, and that death occurred, on the date stated above, at 19:15 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bilateral lobar pneumonia
100
151
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) chronic cardiovascular renal disease
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

100
0 DID AN OPERATION PRECEDE DEATH? **No** DATE OF

WAS THERE AN AUTOPSY? **yes**

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) **DeChernan**, M. D.

575, 1931 (Address) **City Hosp**

*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

5/27/31

20. UNDERTAKER

T.P. Schaffer

ADDRESS

429 The Eagle

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.

