

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

Do not use this space.

1932
1003

10555

1. PLACE OF DEATH

County.....
Township.....
City..... *St. Louis Mo*

Registration District No.....
Primary Registration District No.....

File No.....
Registered No. *2619*
St. Ward)

2. FULL NAME

(a) Residence. No. *4244 Hartford St.* *Mary A. Hadd* St. *16* Ward. *1*
(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. (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) *Widow*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Feb 9 1856*

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
76 1 7

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) *At Home*
St. Paul
Minn. U.S.

10. NAME OF FATHER *Unknown*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

12. MAIDEN NAME OF MOTHER *Unknown*

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

14. INFORMANT..... *Alphonse Hadd*
(Address) *4244 Hartford St.*

15. FILED *18 1932* REGISTRAR *Max C. Starnes*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Mar 16 1932*
17. *No Physician in Attendance.*
I HEREBY CERTIFY, That I attended deceased from.....

....., 19....., to....., 19....., and that I last saw h..... alive on....., 19..... and that death occurred, on the date stated above, at.....

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Showing Myocarditis
930 *Edema of Lung*
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED *Home*
IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY? *Yes*

WHAT TEST CONFIRMED DIAGNOSIS (Signed) *John J. Hurley* M. D.

3/18, 1932 (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 *Cabany Cem.* DATE OF BURIAL *3-19 1932*

20. UNDERTAKER *John J. Robert* ADDRESS *1905 S. Grand Blvd*

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.

