

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

Do not use this space.

11072

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1103**
City **St. Louis** (No. **City, Hospital**)

File No.....
Registered No. **3156**
St. Ward)

2. FULL NAME

(a) Residence, No. **1529 Franklin St.** Ward.
(Usual place of abode)

Length of residence in city or town where death occurred **43** 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) **widowed**
6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Unknown**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **May 17-1852**

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	79	10	13	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. **nil 107A**
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. **905 111A**
10. Date deceased last worked at this occupation (month and year)..... 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Ohio 2**

13. NAME **David Quinn**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **England**

15. MAIDEN NAME **Mary Scatter**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Ireland 20**

17. INFORMANT (ADDRESS) **Hospital information Grace Hosp City Hospital**

18. BURIAL, CREMATION, OR REMOVAL **Valhalla Cemetery DATE April 19 19**

19. UNDERTAKER (ADDRESS) **Benedict - Michaels 11301 62nd St**

20. FILED **31 1919** **May 1919**

Registra.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Mar. 30th 1932**

22. I HEREBY CERTIFY That I attended deceased from **Feb. 11th 1932 to Mar 30th 1932**

I last saw her alive on **Mar. 30th 1932** Death is said

to have occurred on the date stated above, at **12:20 PM**

The principal cause of death and related causes of importance were as follows:

Atelectasis of lung from thrombosis of pulmonary artery. 107A
Other contributory causes of importance: **Bronchopneumonia Acute fibrinous pericarditis**

Name of operation..... Date of.....
What test confirmed diagnosis **Autopsy** Was there an autopsy? **yes**

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide?..... Date of injury..... 19.....

Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury..... Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?..... If so, specify.....

(Signed) **James H. Simon**, M. D.

(Address) **City Hospital**

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.

Harley