

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

Do not use this space.

18081

**1. PLACE OF DEATH**

County..... Registration District No. **793**  
Township..... Primary Registration District No. **1003**  
City..... **ST. LOUIS, MO.** (No. **3641** **HEBERT ST.**, ..... St. .... Ward)

File No. ....  
Registered No. **5053**  
St. .... Ward)

**2. FULL NAME** **MICHAEL J. LEARY.**

(a) Residence, No. **3641** **HEBERT ST.**, ..... St., **10** Ward.  
(Usual place of abode) (If nonresident, give city or town and State)  
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.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX **MALE.** 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 **RITA LEARY.**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **3/23/1876.**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
**56 2 2**

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. **NEWSPAPER. 196**  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. **Supervisor CIRCULATING DEP'T.**  
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) **NEW YORK CITY. NEW YORK.**

FATHER 13. NAME **JACOB LEARY.**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **NEW YORK.**

MOTHER 15. MAIDEN NAME **NOT KNOWN.**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **" "**

17. INFORMANT **Mr. Rita Leary**  
(ADDRESS) **3641 HEBERT ST.**

18. BURIAL, CREMATION, OR REMOVAL PLACE **St. Peters** DATE **5-27-32**

19. UNDERTAKER **Provoch and Co**  
(ADDRESS) **3710 N. GRAND BL'VD**

20. FILED **MAY 25 1932** **Max C. Stankov** Registrar.

**2 MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **5/25/32** . 19

22. I HEREBY CERTIFY, That I attended deceased from **May 24**, 19**32**, to **May 25**, 19**32**  
I last saw him alive on **May 25**, 19**32** Death is said to have occurred on the date stated above, at **12-30m. A.M.**  
The principal cause of death and related causes of importance were as follows:

Date of onset  
**Paralytic Hemiplegia of May 24**  
**930 Paralysis reflexa**  
**930**  
Other contributory causes of importance: **0**  
**myocarditis chronic**

Name of operation..... Date of.....  
What test confirmed diagnosis? **930** Was there an autopsy?.....

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? **no**  
If so, specify.....  
(Signed) **Joseph Hill**, M. D.  
(Address) **3636 Hebert**

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.

RECORDS DEPARTMENT—THIS IS A PERMANENT RECORD

