

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

Do not use this space.

1. PLACE OF DEATH

County.....
Township.....
City.....
Registration District No. *701*
Primary Registration District No. *1028B*

File No. *3587*
Registered No. *522*
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. *5030 St. Louis Ave* 6 Ward.

(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

MEDICAL CERTIFICATE OF DEATH

3. SEX <i>Male</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>Married</i>
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>Aug. 5, 1887</i>		
7. AGE YEARS <i>45</i>	MONTHS <i>5</i>	DAYS <i>8</i>
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <i>Shoemaker</i>		
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <i>Shoemaker</i>		
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) <i>St. Louis, Mo.</i>		
13. NAME <i>John Walsh</i>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Ireland</i>		
15. MAIDEN NAME <i>Catherine Moran</i>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Ireland</i>		
17. INFORMANT (ADDRESS) <i>5030 St. Louis Ave</i>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <i>St. Vincent's</i> DATE <i>Jan. 16, 1933</i>		
19. UNDERTAKER (ADDRESS) <i>1422 1/2 E. Grand Blvd</i>		
20. FILED <i>JAN 15 1933</i> Registrar		

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Jan 13 1933*

22. I HEREBY CERTIFY, That I attended deceased from *Jan 7 1933* to *Jan 13 1933*
I last saw him alive on *Jan 13 1933* Death is said to have occurred on the date stated above, at *1:15 PM*.
The principal cause of death and related causes of importance were as follows:
Carcinoma of the Rectum
Date of onset *7-20-32*
Rectum

Other contributory causes of importance: *4-6-32*

Name of operation..... Date of.....
(What test confirmed diagnosis? *Physical* Was there an autopsy? *No.*)

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) *E. B. Kinder*, M. D.
(Address) *1422 1/2 E. Grand Blvd*

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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MOTHER FATHER

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101-101

101

END