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

Do not use this space.

File No. 24860

Registered No. 6272

1. PLACE OF DEATH

County ..... Registration District No. .....

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

City St Louis (No. 2209 Hebert St St. ..... Ward)

2. FULL NAME Sibina Regan

(a) Residence. No. 2209 Hebert St., 20 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
female	white	single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown 1858

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75.	—	—	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) none
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Ireland

PARENTS

10. NAME OF FATHER Michael Regan 15

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) England 15

12. MAIDEN NAME OF MOTHER Alice Tarney 15

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

14. INFORMANT Sister Jeanne
(Address) 2209 Hebert

15. FILED JUL 19 1933, 19.....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 19th 1933

17. I HEREBY CERTIFY, That I attended deceased from July 11, 1933 to July 19, 1933 that I last saw h. alive on July 18, 1933, and that death occurred, on the date stated above, at 8 A M m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

10 75 Bronchopneumonia 8
9 7
(duration) 7 yrs. mos. 7 ds.

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

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

O DID AN OPERATION PRECEDE DEATH? No DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical Examination

(Signed) Anthony A. Prehoske M. D.

7/19, 1933 (Address) 1525 a Cass Ave.

*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	July 21st 1933
20. UNDERTAKER	**ADDRESS**
Arthur J. Donnelly and Co	2039 Ward St

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.

AUG 2 0 1933