

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.

APR 25 1934

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

Do not use this space.

1. PLACE OF DEATH

County Registration District No. **791**
Township Primary Registration District No. **1003**
City **St. Louis** (No. **Josephine Hospital**) St. Ward)

10923

File No.
Registered No. **2774**
St. Ward)

2. FULL NAME

James Walsh
(a) Residence No. **3217** - **St Vincent** St. **17** Ward.

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 **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Single**

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Aug - 1854**

7. AGE YEARS **79** MONTHS **-** DAYS **-** If LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. **Labourer**
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. **not employed**
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) **Ireland**

MOTHER 13. NAME **Thomas Walsh**

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

15. MAIDEN NAME **Bridget O'Hard**

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

17. INFORMANT **Katherine Walsh** (ADDRESS) **3217 St Vincent St**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Calvary Church** DATE **Mar 22 1934**

19. UNDERTAKER **Rich Ben** (ADDRESS) **2029 Lafayette St**

20. FILED **21 1934** **J. Brebeck** Registrar.

4 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Mar 19 1934**

22. I HEREBY CERTIFY, That I attended deceased from **2/27** 1934, to **3/19** 1934
I last saw him alive on **3/19** 1934. Death is said to have occurred on the date stated above, at **7 A** m.

The principal cause of death and related causes of importance were as follows:
Fracture of right hip
Acute Bronchitis
Acute Myocarditis
Date of onset **3/27/34**
Other contributory causes of importance:
Acute Bronchitis
Acute Myocarditis
3/13/34
3/15/34

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 **Accident** Date of injury **4/1/34**, 19.....
Where did injury occur? **Home St Louis Mo**
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. **Home**
Manner of injury **Falling on floor**
Nature of injury **Fracture of Rt hip**

24. Was disease or injury in any way related to occupation of deceased? **No**
If so, specify
(Signed) **Stephen Vezeau** M. D.
(Address) **3202 Park**
(Vezeau)

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