

**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. **1607**
 City **St. Louis Mo.** (No. **St. John's Hospital**)

File No. **18148**
 Registered No. **4602**
 St. Ward)

2. FULL NAME

Margaret Walsh
 (a) Residence, No. **42708 N. 21st St.** St. **20** Ward.
 (Usual place of abode)

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 **Female** 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 **Michael**
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Aug 3rd 1877**
 7. AGE YEARS **56** MONTHS **9** DAYS **2.** If LESS than 1 day, hrs. or min.
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. **House work**
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

OCCUPATION

FATHER

MOTHER

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **St. Louis Mo.**
 13. NAME **Thomas Carroll**
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Ireland**
 15. MAIDEN NAME **Winifred Griffin**
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Ireland**
 17. INFORMANT (ADDRESS) **Mike Walsh**
 18. BURIAL, CREMATION, OR REMOVAL PLACE **Calvary** DATE **May 8th 1934**
 19. UNDERTAKER (ADDRESS) **Aug. Brookland R & Co**
 20. FILED **1934**

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **May 5th 1934**
 22. I HEREBY CERTIFY, That I attended deceased from **3/24** 19**34** to **5/5** 19**34**
 I last saw her alive on **5/5** 19**34** 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:

ac Cardiac Failure Date of onset **5/5/34**
ac Bronchitis & Pulmonary Grains **5/1/34**
apex of neck with **5/1/34**
Loosened obstruction
 Other contributory causes of importance:
Cholerae Bladder **1934**
with stone **1934**

Name of operation **Removal of Gall Bladder** Date of **4/17/34**
 What test confirmed **Specimen** Was there an autopsy? **Yes**

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? **no** 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) **George J. McManis** M. D.
 (Address) **1006 S. Jefferson av.**

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.

MAY 19 1934

