

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

Do not use this space.

19087

**1. PLACE OF DEATH**

County St. Louis  
Township Carondelet  
City (No. One St. Rose Hosp)

Registration District No. 1523  
Primary Registration District No. 67489

File No. ....  
Registered No. 183  
St. .... Ward)

**2. FULL NAME**

(a) Residence No. 2939 Kemette St St. .... Ward. St. Louis Mo.  
(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 W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 27 - 1901

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
33 1

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work Salesman  
(b) General nature of industry, business, or establishment in which employed (or employer) .....  
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) Boonville Ind  
(STATE OR COUNTRY)

10. NAME OF FATHER William Caley  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ind  
(STATE OR COUNTRY)  
12. MAIDEN NAME OF MOTHER Louise Miller  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mo  
(STATE OR COUNTRY)

14. INFORMANT Leonia Caley  
(Address) 2939 Kemette St

15. FILED 5-28-34 Bohgate Md REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5/27 1934

17. I HEREBY CERTIFY, That I attended deceased from 7/1/34  
Jan 10, 1934, to May 27, 1934,  
that I last saw h. p. m. alive on 5-28-34, 1934, and that  
death occurred, on the date stated above, at 5:35 a m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Pulmonary tuberculosis  
23 1/2  
23 1/2 (duration) 3 yrs. mos. ds.  
CONTRIBUTORY Pulmonary hemorrhage  
(SECONDARY) (duration) 3 yrs. mos. 3 ds.

18. WHERE WAS DISEASE CONTRACTED 23  
IF NOT AT PLACE OF DEATH. ....

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

WAS THERE AN AUTOPSY? Yes  
WHAT TEST CONFIRMED DIAGNOSIS Xray - Rat  
(Signed) John P. Devine, M. D.

3/27, 1934 (Address) 9101 So. Bldg

\*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 Calvary DATE OF BURIAL May 29 1934

20. UNDERTAKER Edw. F. Howard ADDRESS 4262 St Louis Ave

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.

JUN 26 1934

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Edgar

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