

**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.....

(No. **4960**, *Northward Pl.*)

File No. **26936**

Register No. **7169**

St. _____ Ward _____

2. FULL NAME *Mary A. Larionian*

(a) Residence, No. *49160 Northward Pl.* Ward. *6*

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *- - 1849*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. *About 85 - - - -*

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Domestic*
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *at home*
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*

13. NAME *Michael O'Shea*

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

15. MAIDEN NAME *McKinnon*

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

17. INFORMANT (ADDRESS) *Mrs. Margaret O'Shea*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Calvary July 23, 1934*

19. UNDERTAKER (ADDRESS) *Chas. T. Stewart*

20. FILED *21 1934* *Joe J. Bredeek* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *July 20 1934*

22. I HEREBY CERTIFY, That I attended deceased from *July 15 1934*, to *July 20 1934*

I last saw her alive on *July 20 1934*. Death is said to have occurred on the date stated above, at *10:30 a.m.*

The principal cause of death and related causes of importance were as follows:

Acute Lobar Pneumonia

Date of onset

10:30 a.m. 1934

Other contributory causes of importance:

arteriosclerosis

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

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?.....

If so, specify

(Signed) *W. H. White*, M. D.

(Address) *2807 Whipp Highway*

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 13 1934

MISSOURI STATE BOARD OF HEALTH—THIS IS A PERMANENT RECORD

