

NOV 13 1934

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

Do not use this space.

37283

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City, *St. Louis* (No. *3641, Palm St*) St. Ward)

File No.
Registered No. **9677**
St. Ward)

2. FULL NAME

James Cabbe
(a) Residence, No. *3641 Palm St.* *10* 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 *M.* 4. COLOR OR RACE *W.* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Single*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Dec 18, 1866*

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
67 10 14

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Mechanic*

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *Illinois P.L.*

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 *Daniel Cabbe*

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

15. MAIDEN NAME *Mary Higginson*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *New Zealand*

17. INFORMANT *Isabelle Cabbe*
(ADDRESS) *3641 Palm St*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Bellefontaine* DATE *10-4-34*

19. UNDERTAKER *Hronosh Und. Co.*
(ADDRESS) *5716 N. Grand Bldg.*

20. FILED *ICT - 2 1934* *J. Brebeck*
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Dec 1st, 1934*

22. I HEREBY CERTIFY, That I attended deceased from *Sept 28*, 1934, to *Oct 1*, 1934.

I last saw him alive on *Oct 1*, 1934. Death is said

to have occurred on the date stated above, at *1:45* p.m.

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

Broncho-Pneumonia Date of onset
following an acute
sterile hemorrhage *1 wk*

Other contributory causes of importance:

Name of operation Date of operation

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) *J. Brebeck* M. D.

(Address) *2206 Howard St.*

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

Mr. H. H. S. 7-8-12-1 p.m.
2206 Howard St