

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.

APR 9 1935

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 Mo.* (No. *City Hwy # 2*) File No. **11299**
Registered No. **2957** St. Ward)

2. FULL NAME

Lula Mc Mahon
(a) Residence, No. *906 So. 10th St.* St., *22* Ward. (If nonresident, give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred *9* 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 *Colored* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED *(write the word) Married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Quincy Mc Mahon*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *3-5-1890*

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
45 0 22

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

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.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *? Miss*

13. NAME *? Peoples*

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

15. MAIDEN NAME *Unknown*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *? Miss*

17. INFORMANT *Quincy Mc Mahon*
(ADDRESS) *2712 Standard St.*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Father Dickson* DATE *4-1-1935*

19. UNDERTAKER *Chas. Funeral Home*
(ADDRESS) *2820 Standard St.*

20. FILED **MAR 30 1935** *J. T. Brebeck*
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *3-27-1935*

22. I HEREBY CERTIFY, That I attended deceased from, 19....., to....., 19.....

I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at *6:50 P.*

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

Chronic Myocarditis, Arterio-sclerosis, Chronic Interstitial Nephritis, Cirrhosis Liver.

Other contributory causes of importance: *12481*

Name of operation..... Date of.....
What test confirmed diagnosis?..... Was there an autopsy? *Yes*

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) *Harold J. May*, M.D.
(Address) *Optics*

