

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.

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

Do not use this space.

OCT 28 1935

30605

1. PLACE OF DEATH

County St. Louis Registration District No. 789
 Township Central Primary Registration District No. 6033
 City Normandy (No. Immaculate Heart Convent. St. _____ Ward _____)

File No. _____
 Registered No. 228

2. FULL NAME

Mary Brennan

(a) Residence, No. 7626 Natural Bridge Rd. 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 <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widowed.</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Michael Brennan.</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Dont Know.</u>		
7. AGE YEARS <u>About 74</u>	MONTHS <u>--</u>	DAYS <u>--</u>
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>At home.</u>		If LESS than 1 day, hrs. or min.
OCCUPATION	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.	11. Total time (years) spent in this occupation
	10. Date deceased last worked at this occupation (month and year)	

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 11 1935

22. I HEREBY CERTIFY, That I attended deceased from 2-10 1929 to 9-11 1935
 I last saw her alive on 7-11 1935 Death is said to have occurred on the date stated above, at 2:25 P. m.
 The principal cause of death and related causes of importance were as follows:
Thrombosis of cerebral artery
151
 Other contributory causes of importance:
Chr. nephritis
Arterio sclerosis
 Date of onset 10 yrs
11

Name of operation none Date of _____
 What test confirmed diagnosis? phys. Was there an autopsy? No

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? None
 If so, specify _____
 (Signed) Dr. H. Schubert M. D.
 (Address) 736 1/2 North 13th

MOTHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ireland.</u>
	13. NAME <u>Dont Know.</u>
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Dont Know.</u>
	15. MAIDEN NAME <u>Dont Know.</u>
FATHER	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Dont Know.</u>
	17. INFORMANT <u>ADJ Falk</u> (ADDRESS) <u>3180 Lemf ave</u>
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Calvary Cem.</u> DATE <u>Sept. 13, 1935</u>	
19. UNDERTAKER (ADDRESS) <u>J. H. Hickman & Co.</u> <u>2842 Meramec St.</u>	
20. FILED <u>9-12</u> 19 <u>35</u> <u>Ad. Boehmer</u> Registrar.	

