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.

OCT 23 1935

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

Do not use this space.

30835

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St Louis (No. DePaul Hospital St. ..... Ward)

File No. .....

Registered No. 7619

2. FULL NAME Anne D. Walsh

(a) Residence, No. 6611 Washington Ave St., N R 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 Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Unknown 1885

7. AGE YEARS 50 MONTHS Unknown DAYS If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION

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

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) St Louis

FATHER

13. NAME Thomas Walsh

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

MOTHER

15. MAIDEN NAME Annie Connell

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

17. INFORMANT Clare McDonald
(ADDRESS) 6611 Washington Ave

18. BURIAL, CREMATION, OR REMOVAL
PLACE Calvary Cemetery DATE 9/11 1935

19. UNDERTAKER Arthur H. Donnelly
(ADDRESS) 3840 Kindell Blvd

20. FILED SEP 11 1935 19 J F Bredeck
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9/9, 1935

22. I HEREBY CERTIFY, That I attended deceased from Aug. 1st, 1935, to Aug. 9, 1935

I last saw ✓ alive on Aug 9, 1935. Death is said to have occurred on the date stated above, at 2:30 P.m.

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

Lung Abscess, with gangrene of rt. low & lobe. Non T.B. non traumatic

Date of onset 2 wks.

Other contributory causes of importance: 1461

Abscesses and gangrene caused by Bronchiectasis

Name of operation None Date of

What test confirmed diagnosis? Exam & autopsy 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? No

If so, specify .....

(Signed) D. B. Flavan, M. D.

(Address) 1114 Mo. Bldg

Walsh

12-3-[illegible]