

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

Do not use this space.

17453

1. PLACE OF DEATH

**MAY 31 1937**  
County *St. Francois*

Registration District No. *773*

File No. \_\_\_\_\_

Township \_\_\_\_\_

Primary Registration District No. *4464*

Registered No. *73*

City *Farmington* (No. \_\_\_\_\_)

St. \_\_\_\_\_

Ward \_\_\_\_\_

2. FULL NAME *Mary Joyce Walsh*

(a) Residence, No. \_\_\_\_\_

St. \_\_\_\_\_

Ward \_\_\_\_\_

(If nonresident, give city or town and State)

(Usual place of abode)

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) *Married*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *1-21-1891*

7. AGE

YEARS *46*

MONTHS *2*

DAYS *18*

If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

OCCUPATION

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

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) *Northville, Ky*

FATHER

13. NAME *W. R. Joyce*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Niagara, Canada*

MOTHER

15. MAIDEN NAME *Lillian Jenkins*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Simpshellville, Ky*

17. INFORMANT (ADDRESS) *Thomas Walsh Farmington, Mo*

18. BURIAL, CREMATION, OR REMOVAL

PLACE *Parkview*

DATE *4-10 1937*

19. UNDERTAKER (ADDRESS) *Reidert Lind Co Farmington Mo*

20. FILED *apl 9 1937 B J. Robinson Registrar.*

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *4-8 1937*

22. I HEREBY CERTIFY, That I attended deceased from *May 1933*, to *April 7 1937*

I last saw him alive on *April 6 1937*. Death is said to have occurred on the date stated above, at *8:15 a.m.*

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

*Uremia -*  
*Urteral Stenosis - Cardiac Failure -*

Date of onset *4-7-37*

Other contributory causes of importance: *920*

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in 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) *Geo. R. Watkins*

M. D.

(Address) *Farmington, Mo.*

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.

92a

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County St. Francois

Registration District No. 773

Township

Primary Registration District No. 4464

City Farmington (No. \_\_\_\_\_)

File No. 17453

Registered No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Mary Jones Walsh

(a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ 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

F

4. COLOR OR RACE

W

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

m

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

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

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

46

2

18

OCCUPATION

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

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)

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE

DATE

19

19. UNDERTAKER (ADDRESS)

20. FILED

4/30/1937

1937

B. J. Robinson  
Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-8-37, 1937

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

I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows: \_\_\_\_\_ Date of onset \_\_\_\_\_

Pneumonia caused by myocarditis

Other contributory causes of importance: \_\_\_\_\_

myocarditis

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) Geo. L. Walker, M. D.

(Address) Farmington, Mo.

**SUPPLEMENTARY**

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.  
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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