

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.

5 1939

REC'D JUN 8 1939

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

19798  
Do not use this space.

1. PLACE OF DEATH

(a) County St. Louis Registration District No. 784  
(b) Township Richmond Heights Primary Registration District No. 111  
(c) City Richmond Heights (d) Street No. 1033 Yale St. \_\_\_\_\_  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. 814

2. PRINT FULL NAME Mary Jane Bryce

(a) Residence, No. 1033 Yale St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF W. J. Bryce  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 1, 1873  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
65 8 3

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife  
9. Industry or business in which work was done, as 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) Ireland 5

FATHER 13. NAME Bernard O'Conner 5

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland 5

MOTHER 15. MAIDEN NAME Mary Cusick

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

17. INFORMANT (ADDRESS) Margaret POWERS  
1033 Yale

18. BURIAL, CREMATION, OR REMOVAL PLACE Lake Charles Cem. DATE May 6, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Jay B. Smith  
7456 Manchester

20. FILE MAY - 5 1939 D. R. Meyer (Address) 717

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) MAY 4, 1939, 19

22. I HEREBY CERTIFY, That I attended deceased from 2/2, 1939 to 5/4, 1939  
I last saw him alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at 6 A. m.  
The principal cause of death and related causes of importance were as follows:

Coronary Thrombosis  
Hypertension  
Bronchial asth.  
Other contributory causes of importance: 94h  
Dr. A. M. ...  
249p

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) Dr. A. M. ... M. D.  
634 N. Grand St.

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, .....

or by .....

Registered Apprentice No. ...., working under my personal supervision.

Signed.....

Licensed Embalmer No. 4029

P. O. Address .....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**