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.

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

1 PLACE OF DEATH

County .....

Township ..... or Village ..... or City St Louis Mo (NO. Mullanphy Hospital St. Ward)

Registration District No. 791 File No. 31040

Primary Registration District No. 1003 Registered No. 8987

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Jeanette Walsh

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Aug (Month) 26 (Day) 1898 (Year)

7 AGE: 20 yrs. 1 mos. ds.

If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer): 1 123 Ri 12

9 BIRTHPLACE (City or town, State or foreign country): St Louis Mo

PARENTS

10 NAME OF FATHER: Thomas Lawlor

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Mahan

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edward Walsh
(Address) 3143a N 13th St

15
Filed Oct 28 1918 Max C. Starkloff Registrar

3 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept (Month) 27 (Day) 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Sept 27, 1918, to Sept 27, 1918, that I last saw h. alive on Sept 27, 1918, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

Peritonitis following perforation of bowel.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) 117

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Burdick M. D.

9/28/18 1918 (Address) 2106 E Grand

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. 2 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence 3143a N 13th St

19 PLACE OF BURIAL OR REMOVAL: Calvary

DATE OF BURIAL: Sept 30 1918

20 UNDERTAKER: Math Heerman 4141

ADDRESS: N Florissant

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

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

..... (Month) ..... (Day), 1..... (Year)

7 AGE ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER
(City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ..... 191..... .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) ..... (Day), 191..... (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191.....
that I last saw h..... alive on ....., 191.....,
and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....
.....
.....
..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL | **DATE OF BURIAL** ....., 191.....

20 UNDERTAKER | **ADDRESS**

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.

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