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

Do not use this space.
22718

1. PLACE OF DEATH

County..... Registration District No. 701 File No. 6882

Township..... Primary Registration District No. 1003 Registered No. 6882

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

2. FULL NAME Mary Walsh

(a) Residence. No. 2613 Sheridan St., 21 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Widowed

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

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

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
About 54	—	—	

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

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

PARENTS

10. NAME OF FATHER Unknown Jennings

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Ireland

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) " "

14. INFORMANT James Walsh
(Address) 2613 Sheridan Av

15. FILED 11 12 1927 Marie Starsoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-9 1927

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19..... that I last saw b..... alive on ....., 19....., and that death occurred, on the date stated above, at 11 10 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Shock & Injuries
Contusion
Struck by Auto in
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) City accident
(duration) yrs. mos. ds.

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18. WHERE WAS DISEASE CONTRACTED?
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY? Yes
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Wm Dyer M. D.
7/11 1927 (Address) City Morgue

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Calvary — DATE OF BURIAL 7-13 1927

20. UNDERTAKER Arthur J Donnelly — ADDRESS 2039 Ritt St

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.

Borneo Office