

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

Do not use this space.

31593

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis Mo**

No. **1904 California Av.**

File No.....

Registered No. **8929**

St. **10**

Ward)

2. FULL NAME

Frances Frichette

(a) Residence No. **1904 California**

St. **23**

Ward.

(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)

widow

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

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

March 25-1864

7. AGE

63

6

10

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

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Housekeeper

(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)

Mo.

10. NAME OF FATHER

John Lahey

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)

Ireland

14.

INFORMANT (Address)

**Mr. John Frichette
1904 California Av.**

15.

FILED

OCT - 6 1927

Max C. Starkeoff

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

Oct 5 1927

17.

I HEREBY CERTIFY That I attended deceased from

....., 1927, to **Oct 5**, 1927, that I last saw him alive on **Oct 4**, 1927, and that death occurred, on the date stated above, at **10:25 A.M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

**Cerebral Apoplexy
8:20 AM
97 1401**

CONTRIBUTORY (SECONDARY)

Arterio-sclerosis

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH? DATE OF.....

WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS? **Clinical**

(Signed) **Dr. W. M. Payton, M. D.**
2759 Lafayette

*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

DATE OF BURIAL

St. Genevieve Mo., Oct 7 1927

20. UNDERTAKER

ADDRESS

E. J. Schurer 3125 Lafayette

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.

