

MAR 26 1928

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

Do not use this space.

2498

1. PLACE OF DEATH

County St. Louis Registration District No. 1170 File No. 1
 Township Central Primary Registration District No. 6248H Registered No. 13
 City Richmond Heights St. Marys Hospital St. _____ Ward _____

2. FULL NAME

Mary Byrone Brown
 (a) Residence No. 5107 Nelson St. _____ Ward _____ St. Louis, Mo
 (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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

David Brown

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Under 1863

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
65

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)

Ohio

10. NAME OF FATHER

James Byrone

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ireland

12. MAIDEN NAME OF MOTHER

Rosetta Byrone

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ireland

14.

INFORMANT

(Address)

Harry H. Lint
5206 Raymond

15.

FILED

1/14, 1928

W. K. Jensen
REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-13-1928

17.

I HEREBY CERTIFY, That I attended deceased from Dec. 10, 1927, to Jan. 13, 1928 that I last saw her alive on 1-13, 1928, and that death occurred, on the date stated above, at 8 m.

THE CAUSE OF DEATH* AS FOLLOWS:

Cerebral Thrombosis -
(Thrombosis of left internal carotid artery as it enters the brain)

(duration) yrs. mos. ds. 3

CONTRIBUTORY (SECONDARY) Arterio-sclerosis and Hypertension

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

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

20. WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? Exam. & autopsy

(Signed) Fred H. Steley M. D.

1-14-1928 (Address) 4501 Manchester

*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

Le abary

1-16 1927

20. UNDERTAKER

ADDRESS

Arthur J. Donnelly 2039 North St

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.

Q 5086

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

1964

10

**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. Louis

Registration District No. 1170

File No. 13

Township Richmond Heights

Primary Registration District No. 6248

Registered No. 13

City Richmond Heights

St. St. Louis Ward Mo.

2. FULL NAME

Mary Byrne Brown

(a) Residence No. 1 St. St. Louis Ward Mo.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) W.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 1863

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
65 - - -

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. da.
(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)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14.

INFORMANT (Address)

FILED 4/14 1928 C. L. Jensen REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 13 1928

17. I HEREBY CERTIFY, That I attended deceased from Jan 13, 1928, to Jan 13, 1928, that I last saw h. eye of eye, 1928, and that death occurred, on the date stated above, at 11:16 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS.....

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

, 19 (Address)

*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

20. UNDERTAKER

ADDRESS

ALL STATE AND COUNTY INFORMATION MUST BE WRITTEN ON THIS SUPPLEMENTARY. ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY. ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

SUPPLEMENTARY

11/16 1928

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