

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

Do not use this space.

**1. PLACE OF DEATH**

County.....  
Township.....  
City..... *St. Louis*

Registration District No. *791*  
Primary Registration District No. *1003*  
(No. *4973 - Columbia 4*)

File No. *15037*  
Registered No. *13954*  
St. .... Ward

**2. FULL NAME**

*Mary E. Springer*

(a) Residence. No. .... St. *13* Ward.

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. (If nonresident give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <i>Female</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Widowed</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Walter G Springer</i>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>July 10 - 1896</i>		
7. AGE	YEARS <i>51</i>	MONTHS <i>8</i>
	DAY <i>28</i>	IF LESS than 1 day, <i>hrs.</i> or <i>min.</i>

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) *St. Louis*  
(STATE OR COUNTRY)

10. NAME OF FATHER *John Lynch*

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

12. MAIDEN NAME OF MOTHER *Ellen Haley*

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

14. INFORMANT *Mr. Joseph W. Lawrence*  
(Address) *4973 Columbia 4*

15. FILED *APR 10 1928*  
19. *May C. Stanley*  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

3

16. DATE OF DEATH (MONTH, DAY AND YEAR) *4/8 1928*

17. I HEREBY CERTIFY, That I attended deceased from *Feb. 27*, 19*28*, to *April 8*, 19*28* that I last saw her alive on *April 6*, 19*28* and that death occurred, on the date stated above, at *67 1/2* m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*Apoplexy - cerebral hemorrhages*  
(duration) yrs. *1* mos. *11* ds.

CONTRIBUTORY (SECONDARY) *Chronic interstitial Nephritis and Hypertension*  
(duration) yrs. *1* mos. *1* ds.

18. WHERE WAS DISEASE CONTRACTED *1041 W. 13th*  
IF NOT AT PLACE OF DEATH *827*

DID AN OPERATION PRECEDE DEATH? *NO* DATE OF *12*

WAS THERE AN AUTOPSY? *NO*

WHAT TEST CONFIRMED DIAGNOSIS *g. chemical*

(Signed) *A. J. Reardon* M. D.  
*4-9-1928* (Address) *1041 Missouri Bz*

\*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 *4-11 1928*

20. UNDERTAKER *Arthur J. Donnelly* ADDRESS *2069 Wash 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.

Mr. W. W. Belmont

Mo. Bldg  
1-3