

AY 29 1929

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

Do not use this space.

15941

1. PLACE OF DEATH
 County St. Louis Registration District No. 1170
 Township Richmond Heights Primary Registration District No. 6248H
 City Richmond Heights St. Marys Hospital St. _____ Ward _____
 2. FULL NAME Katherine O Leary
 (a) Residence. No. 5108 Page W St. _____ Ward. _____
 (Usual place of abode) (If nonresident give City or town and State)
 Length of residence in city or town where death occurred yrs. 3 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) Single
 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 53 — — — — —
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Clerk - C.A. R.R.
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 21 1929
 17. I HEREBY CERTIFY, That I attended deceased from April 1 to April 21, 1929
 that I last saw her alive on April 21, 1929, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Exophthalmic Goiter
66B

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH, _____
 DID AN OPERATION PRECEDE DEATH? No DATE OF _____
 WAS THERE AN AUTOPSY? Yes
 WHAT TEST CONFIRMED DIAGNOSIS? Microscopic
Kate C. Spain, M. D.
 (Signed) _____
April 23 1929 (Address) 1516 Page

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Mo
 10. NAME OF FATHER Patk O Leary
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Ireland
 12. MAIDEN NAME OF MOTHER Johanna Curran
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Ireland

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH, _____
 DID AN OPERATION PRECEDE DEATH? No DATE OF _____
 WAS THERE AN AUTOPSY? Yes
 WHAT TEST CONFIRMED DIAGNOSIS? Microscopic
Kate C. Spain, M. D.
 (Signed) _____
April 23 1929 (Address) 1516 Page
 *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.

14. INFORMANT B. O. Ormbruster
 (Address) 417 Paul Brown Bldg.
 15. FILED 4/23 1929 B. L. Jensen REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL balcony DATE OF BURIAL April 24 1929
 20. UNDERTAKER Bullman Kelly ADDRESS 4526 Easton

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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11/15/11

11/15/11 (DATE)
J. M. Bennett