

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

Do not use this space.

29636

1. PLACE OF DEATH

County.....

Registration District No.....

Township.....

Primary Registration District No.....

City *St. Louis*

(No. *City & Hospital*)

File No.....

Registered No. *8825*

St.....

Ward)

2. FULL NAME

(a) Residence. No. *3726 Forest* Ward. *18*

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *30* 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

married

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

Peter Dwyer

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

Aug-1-1867

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<i>62</i>	<i>0</i>	<i>26</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)

(STATE OR COUNTRY)

Ohio

10. NAME OF FATHER

unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

unknown

12. MAIDEN NAME OF MOTHER

" "

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

" "

14.

INFORMANT (Address)

City of St. Louis

15.

FILED

19

Arthur J. Donnelly
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Aug 27 1929

17.

I HEREBY CERTIFY that I attended deceased from *Aug 28*, 19*29*, to *Aug 27, 1929*, that I last saw him alive on *Aug 27, 1929*, and that death occurred, on the date stated above, at *10530*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

*Chr. Interstitial Nephritis
arteriosclerosis & Hypertension*

CONTRIBUTORY (SECONDARY)

Uremia (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

2726 Forest PK. Blvd

DISSEMINATION PRECEDE DEATH? *no*

DATE OF *✓*

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS?

Blood NPN

(Signed) *Ben Margolis*, M. D.

827, 19*29* (Address) *City & Hospital*

*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

Valhalla Cemetery

830 1929

20. UNDERTAKER

ADDRESS

Arthur J. Donnelly 2039 Wash &

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.

Drayer.