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

Do not use this space.

File No. 17376

Registered No. 4438.

1. PLACE OF DEATH

County ..... Registration District No. 781

Township ..... Primary Registration District No. 1003

City St Louis (No. 4431 McPherson St. ..... Ward)

2. FULL NAME Mary J Rohan

(a) Residence. No. ..... St., 19 Ward. .....
(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Female	White	Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) September 1847

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
abt	83	Unknown		

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) Ills

PARENTS

10. NAME OF FATHER P McGovern

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

12. MAIDEN NAME OF MOTHER Bridget Reilly

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

14. INFORMANT James M Rohan
(Address) 4431 McPherson St

15. FILED ....., 19.... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 3rd 1930

17. I HEREBY CERTIFY, That I attended deceased from April 29th, 1930, to May 3rd, 1930 that I last saw her alive on May 2nd, 1930 and that death occurred, on the date stated above, at 10 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchio Pneumonia
109A
97 (duration) ..... yrs. mos. 5 ds.

CONTRIBUTORY (SECONDARY) Arteria - Sclerosis
(duration) 10 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? Home
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) J Gallagher, M. D.
5/3, 1930 (Address) 311-313 Wall Bldg

*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
Calvary	5-5 1930
20. UNDERTAKER	**ADDRESS**
Arthur J Donnelly	2039 Wash St

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.

2

15

Wall Bldg.
3-