

JAN 24 1935

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

Do not use this space.

45166

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City **St. Louis** (No. **4230**) **Claveland Ave** St. Ward)

File No.
Registered No. **1232**

2. FULL NAME

(a) Residence, No. St., **17** 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 <i>Female</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>Widow</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Patrick J. Shea</i>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>May 8 - 1843</i>		
7. AGE YEARS <i>91</i>	MONTHS <i>7</i>	DAYS <i>20</i>
If LESS than 1 day, hrs. or min.		

OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <i>at home</i>
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
	10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ireland*

MOTHER FATHER 13. NAME *Michael Moran*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ireland*

MOTHER 15. MAIDEN NAME *Mary O'Connell*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ireland*

17. INFORMANT (ADDRESS) *Anna B. Shea 4230 Claveland Ave*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Calvary Cemetery* DATE *12/31 1934*

19. UNDERTAKER (ADDRESS) *Arthur J. O'Connell 3840 Lindell Blvd*

20. FILED *24 1935* *J. J. O'Connell Registrar*

3 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Dec 28th 1934*

22. I HEREBY CERTIFY, That I attended deceased from *Dec 18th 1934* to *Dec 28th 1934*
I last saw her alive on *Dec 27th 1934* Death is said to have occurred on the date stated above, at *6:30 a.m.*
The principal cause of death and related causes of importance were as follows:

chronic myocarditis *12/1/34*
acute bronchitis *10/18/34*
arterio-sclerosis

Other contributory causes of importance:
none

Name of operation *none* Date of
What test confirmed diagnosis? Was there an autopsy? *no*

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury 19.....
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? *no*
If so, specify
(Signed) *J. Gallagher* M. D.
(Address) *Wall Bldg 3903 Olive*

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.

Dr. Gallagher
3900 Main St.
2-5 PM