

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

Do not use this space.

35827

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis** (No. **City Hospital**)

File No.

Registered No. **10630**

St.

Ward)

2. FULL NAME

(a) Residence. No. **2934 Arlington** b. Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred **35** yrs.

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)

married

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

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

Aug 1 - 1894

7. AGE

YEARS **35**

MONTHS **2**

DAYS **18**

If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. **Housewife**

(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 J. McNamee

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Missouri

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Phyllis Brown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

St. Louis

(STATE OR COUNTRY)

14. INFORMANT

(Address) **City Hospital**

15. FILED

Oct 29 1929

W. C. Starkey
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Oct 27 1929

17.

I HEREBY CERTIFY That I attended deceased from **Oct 8**, 19**29**, to **Oct 27**, 19**29**, that I last saw him alive on **Oct 27**, 19**29**, and that death occurred, on the date stated above, at **706 1/2 St.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Far Advanced Pulmonary Tuberculosis
23 1/2 (duration) yrs. **5** mos. **ds.**

CONTRIBUTORY (SECONDARY)

Tuberculous meningitis
(duration) yrs. mos. **6** ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH. **2934 Arlington**

DID AN OPERATION PRECEDE DEATH? **no** DATE OF **no**

WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS?

10/18 (Signed) **Bay Margulies, M.D.**
29, 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

Memorial Park

Oct 31 1929

20. UNDERTAKER

ADDRESS

Stewart & Curran

4608 Nat Bldg

WRITE PLAINLY, WITH UNFADING INK--- THIS IS A PERMANENT RECORD

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.

Gales.