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

Do not use this space.

35250

1. PLACE OF DEATH

County ..... Registration District No. 791

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

City St Louis (No. 1802, Wagoner Place St.) Ward)

File No. ..... Registered No. 10429

2. FULL NAME Betty O'Leary

(a) Residence. No. 1802 Wagoner Pl. St., 6 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.

CAUSE OF DEATH: 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.

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 Jerry

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 4 1855

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	4	16	

8. OCCUPATION OF DECEASED 107 112

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Va

PARENTS

10. NAME OF FATHER Edison Clayborn

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

12. MAIDEN NAME OF MOTHER Mary A Porter

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

14. INFORMANT Ann O Leary
(Address) 1802 Wagoner Pl.

15. FILED Nov 21 1927 Mark Starkoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 20 1927

17. I HEREBY CERTIFY, That I attended deceased from Nov. 17, 1927, to Nov. 20, 1927, that I last saw h.e.r alive on Nov. 19, 1927, and that death occurred, on the date stated above, at 7:15 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchial Pneumania

100 A

(duration) ..... yrs. ..... mos. 9 ds.

CONTRIBUTORY (SECONDARY) Asthma

non Tubercular (duration) 40 yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? No. DATE OF —

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? Physical signs

(Signed) Samuel E Peden, M. D

Nov 21, 1927 (Address) 1109 N Grand

*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
Bonne Terre Mo	Nov 22 1927
20. UNDERTAKER	ADDRESS
Cullen Kelly	4526 Easton

Dr S E Peden
1109 11 Grand
8 to 10 AM 1 to 3 PM