

REC'D MAY 10 1938

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

12899

Do not use this space.

Registered No. 3503

1. PLACE OF DEATH

(a) County Registration District No. **791**
 (b) Township Primary Registration District No. **1003**
 (c) City **St. Louis, Mo.** (d) Street No. **City Hospital #1** St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **Mary Rawlings 452**

(a) Residence, No. **908 N. Euclid** St. **12** (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Widow**

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **7/24/78**

7. AGE YEARS **59** MONTHS **8** DAYS **19** If LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Saleswoman**
 9. Industry or business in which work was done, as 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) **City 1**

FATHER 13. NAME **Wm. Moloney 4**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Scotland 5**

MOTHER 15. MAIDEN NAME **Bridget Kane**

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

17. INFORMANT (ADDRESS) **Hosp. info. M. Williams City Hospital #1**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Calvary** DATE **Apr 15 38**

19. FUNERAL DIRECTOR (NAME) (ADDRESS) **Stroh & Carroll 4600 North Broadway**

20. FILE **APR 14 1938** **J. D. Bredtch** Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **4/13/38** 19

22. I HEREBY CERTIFY, That I attended deceased from **12/16/38** 19 to **4/13/38** 19

I last saw him alive on **4/13/38** 19. Death is said to have occurred on the date stated above, at **5:00 P.M.**

The principal cause of death and related causes of importance were as follows:

Carcinoma of Cervix
H/O

Other contributory causes of importance:

Generalized Metastases Secondary Anemia

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

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?

If so, specify

(Signed) **J. Sanderson**, M. D.

(Address) **615 Lafayette**

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.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by

Registered Apprentice No. _____, working under my personal supervision.

Signed

F.H. Study

Licensed Embalmer No.

2265

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.