

APR 12 1939

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

8742
Do not use this space.
2507

1. PLACE OF DEATH

(a) County 2 Registration District No. 791
(b) Township 1 Primary Registration District No. 1003 Registered No. 2507
(c) City St. Louis (d) Street No. 4915 Farlin 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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

(a) Residence, No. 4915 Farlin St. 7 (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) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF August E. Du Ruz
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 23, 1874
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 64 8 19
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
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) St. Louis Mo.

13. NAME James O Malley

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

15. MAIDEN NAME Bridget Hines

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

17. INFORMANT (ADDRESS) Mamie Delaney 4915 Farlin

18. BURIAL, CREMATION, OR REMOVAL PLACE Calvary Cem. March 17th 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Strook Carroll 4600 Natural Bridge

20. FILED MAR 16 1939
J. F. Budich
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 14, 1939

22. I HEREBY CERTIFY, That I attended deceased from May 7, 1927, to March 14, 1939

I last saw her alive on 3-1-1939 Death is said to have occurred on the date stated above, at 11.0 P. m.

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

Hypertension Arterial
Chronic myocarditis
Chronic Intestinal hyperplasia

Date of onset about 1927

Other contributory causes of importance: Cerebral Hemorrhage apoplexy 3-14-39

Name of operation clinical 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 (LANGSDORF)
(Signed) Herbert S. Langsdorf, M. D.
(Address) 3115 So. Grand

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 *Sheldon Collier*

Licensed Embalmer No. *3382*

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.