

Registration District No. 791
1003

Primary Registration District No. _____

1. PLACE OF DEATH: 1003
(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: DePaul Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Day
(Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Helen Rudd
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife John J. Rudd 6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased August 31 1886
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
52 9 17 _____ hr. _____ min.

9. Birthplace St. Louis Mo (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER { 12. Name John O'Hara 3
13. Birthplace Ireland 5 Ireland
(City, town, or county) (State or foreign country)
14. Maiden name Eileen Ryan
15. Birthplace Ireland Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature John J. Rudd
(b) Address 3301 St. Vincent Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 19 1939
(Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Peetz Brothers
(b) Address 3029 Lafayette

19. (a) JUN 17 1939 (b) J. B. B. B. B.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County _____
(c) City or town St. Louis 117
(If outside city or town limits, write "RURAL")
(d) Street No. 3301 St. Vincent Ave
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month June day 16th
year 1939 hour 1:15 minutes P.M. M.

21. I hereby certify that I attended the deceased from 8/6/1936
_____, 19____, to 6/16/39, 19____;
that I last saw h. is alive on 6/16/39, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Haemorrhage Duration 24 hours

Due to Hypertension

Due to _____

Other conditions Ch. Myocarditis 8/6/36
(Include pregnancy within 3 months of death) Diabetes Mellitus

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

23. Signature Thomas P. Taylor (M. D. or other) _____
Address 2739 N. Grand Date signed 6/17/39

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

Room 220

Jan - 67 30

Mr. Thomas & Associates
Funeral & Home Care

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 Francis J. Swann

Licensed Embalmer No. 2245

P. O. Address St. James Ind

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.