

15 1939
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 WHITE PAPER—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.
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DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

26842

Registration District No. 111

Primary Registration District No. 111

State File No. _____

Registrar's No. 1283

1. PLACE OF DEATH:
 (a) County St. Louis
 (b) City or town Rock Hills
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: ST. MARY'S HOSPITAL
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 hours
 (Specify whether years, months or days) 49 years

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County 1
 (c) City or town ST. LOUIS
 (If outside city or town limits, write "RURAL")
 (d) Street No. 224 N. NEWSTEAD
 (If rural, give locality)
 (e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Mrs. Irene Mc. Auliffe
 3. (b) If veteran, name war _____ 3. (c) Social Security No. none

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced
 6. (b) Name of husband or wife JOSEPH J. Mc AULIFFE 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Aug. 24 1889
 (Month) (Day) (Year)

8. AGE: Years 49 Months 10 Days 20 If less than one day hr. _____ min. _____

9. Birthplace ST. LOUIS Mo.
 (City, town, or county) (State or foreign country)

10. Usual occupation AT HOME

11. Industry or business _____

MOTHER FATHER
 12. Name THOMAS MURRAY
 13. Birthplace ST. LOUIS Mo.
 (City, town, or county) (State or foreign country)
 14. Maiden name AN N. CAVANHOYH
 15. Birthplace ST. LOUIS Mo.
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Irene Mc. Auliffe
 (b) Address 224 N. NEWSTEAD
 17. (a) BURIED (b) Date thereof JULY 17 1939
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation CALVARY

18. (a) Signature of funeral director James J. Callinan
 (b) Address 1710 N. GRAND
 19. (a) JUL 15 1939 (b) J. R. [Signature]
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month July day 14
 year 1939 hour 10 minute 30 P M.
 21. I hereby certify that I attended the deceased from 7:45 PM
July 14, 1939 to 10:30 PM 7/14, 1939;
 that I last saw her alive on July 14, 1939;
 and that death occurred on the date and hour stated above.

Immediate cause of death Heart Stroke Duration 6 hrs

Due to _____
 Due to _____
 Other conditions 191
 (Include pregnancy within 3 months of death)

Major findings: H/D
 Of operations 1
 Of autopsy _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____
 Signature Russell (M. D. or other)
 Address 415 Beaumont Date signed 7/15/39

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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 *Fred Frick*

Licensed Embalmer No. *3186*

P. O. Address *St. Louis MO.*

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.