

WHITE PENCIL—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.

Registration District No. 389 1939

Primary Registration District No. 111

Registrar's No. 1317

1. PLACE OF DEATH:
 (a) County St. Louis
 (b) City or town Rich. N.Y.
 (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 6 weeks
 (Specify whether _____)
 In this community _____
 years, months or days

3. (a) PRINT FULL NAME Rev. John F. Coll. 400
 8. (b) If veteran, name war No.
 8. (c) Social Security No. 300

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced Single
 6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Apr. 23, 1900
 (Month) (Day) (Year)

8. AGE: Years 39 Months 2 Days 27 If less than one day _____ hr. _____ min.

9. Birthplace Pennsylvania
 (City, town, or county) (State or foreign country)

10. Usual occupation Priest

11. Industry or business Thomas Coll. 45

12. Name Thomas Coll.
 13. Birthplace Ireland
 (City, town, or county) (State or foreign country)

14. Maiden name _____
 15. Birthplace Philadelphia Pa.
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Rev. J. F. Coll.
 (b) Address Kirkwood Mo.

17. (a) Burial (b) Date thereof July 24, 1939
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kirkwood Mo. St. Mary's
 18. (a) Signature of funeral director J. J. Quinn

(b) Address 1389 Union Blvd.
 19. (a) JUL 22 1939 (b) G.R. Thompson
 (Date received local registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Mo
 (c) City or town St. Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1118 N. Grand
 (If rural, state location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 20
 year 1939 hour 5 minute 30 a.m.

21. I hereby certify that I attended the deceased from July 1939
 _____, 19____, to July 20, 1939
 that I last saw him alive on July 20, 1939
 and that death occurred on the date and hour stated above.

Immediate cause of death Uremia

Due to chr. nephritis
 Due to _____

Other conditions Hypertension
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations X 131
 Of autopsy X

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 Commetant (M. D. or other)
 Address 3720 Washington Date signed 7/24/39

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

B. W. Ferrin

Licensed Embalmer No. *1391*

P. O. Address *7106 Bolan*

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.