

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. 1003

Primary Registration District No. _____

Registrar's No. 7407

1. PLACE OF DEATH:

(a) County Mo.

(b) City or town ST LOUIS

(c) Name of hospital or institution: 4411 FOREST PARK BLVD.

(d) Length of stay: In hospital or institution _____

In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. 1

(b) County _____

(c) City or town ST LOUIS

(d) Street No. 4411 FOREST PARK BLVD.

(e) If foreign born, how long in U. S. A. _____ years

3. (a) PRINT FULL NAME ELLEN. HALLEY. URIAN.

3. (b) If veteran, name war No

3. (c) Social Security No. No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 25th year 1939 hour 10:30 minute _____ P. M.

4. Sex FEMALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced WIDOW.

6. (b) Name of husband or wife WILLIAM. R. URIAN.

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased SEPT. 25 1865

21. I hereby certify that I attended the deceased from July 12th, 1939, to Aug 25th, 1939

that I last saw her alive on Aug 25th and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis

8. AGE:	Years	Months	Days	If less than one day
	<u>73</u>	<u>11</u>	<u>0</u>	hr. _____ min.

Due to Cerebral Haemorrhage

Due to arterio sclerosis

9. Birthplace Mo.

Duration 1 month

Duration 6 weeks

Duration 5 years

10. Usual occupation AT HOME

Other conditions _____

11. Industry or business _____

12. Name MICHAEL. HALLEY.

13. Birthplace IRELAND

14. Maiden name MARY RYAN

15. Birthplace IRELAND.

Major findings: _____

Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically

16. (a) Informant's own signature William Urian

(b) Address 4411 FOREST PARK BLVD.

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

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

(b) Date of occurrence _____

17. (a) BURIAL. (b) Date thereof AUG 29 1939

(c) Place: burial or cremation CALVARY.

(c) Where did injury occur? _____

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

18. (a) Signature of funeral director L. M. Muller.

(b) Address 5165 DELMAR BLVD.

While at work? _____

(Specify type of place) _____

(e) Means of injury _____

19. (a) AUG 28 1939

23. Signature J. P. Gallagher (M. D. or other) _____

Address Wall Bldg 39 3 @line Date signed 8/26/39

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 Heward T. Rowland

Licensed Embalmer No. 3114

P. O. Address Ot Ravis, M

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.