

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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Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH:
(a) County 2
(b) City or town St. Louis
(c) Name of hospital or institution: 5995 Astra Ave.
(d) Length of stay: _____
In this community _____ years, months or days

3. (a) PRINT FULL NAME Daniel A. Corbett, 613
3. (b) If veteran, name war _____ 3. (c) Social Security No. 493-05-1422
4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widower
6. (b) Name of husband or wife Mae V. Corbett 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Jan. 15 1887
(Month) (Day) (Year)

8. AGE: Years 52 Months 8 Days 22 If less than one day _____ hr. _____ min.

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

10. Usual occupation Asst. Traffic Manager

11. Industry or business Union Electric Co. of Mo.

12. Name James Corbett

13. Birthplace Ireland
(City, town, or county) (State or foreign country)

14. Maiden name Ellen Taffe

15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Thomas J. Corbett

(b) Address 2908 Wacker St

17. (a) Burial (b) Date thereof Oct. 11, 39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Cullinane Bros.
(b) Address 1710 N. Grand Blvd.

19. (a) OCT 10 1939 (b) J. F. Beckwith
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County 1
(c) City or town St. Louis **7**
(d) Street No. 5995 Astra Ave.
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month October day 7th year 1939 hour 4 minute P M.
21. I hereby certify that I attended the deceased from 10/7/39 in AM.
_____ 19____, to 10/7/39 PM. 19____;
that I last saw him alive on 10/7/39, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral apoplexy. Duration 1 d.

Due to Hypertensive cardiac disease

Due to _____

Other conditions None
(Include pregnancy within 9 months of death)

Major findings: Of operations none

Of autopsy none

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 _____

23. Signature H. Klein M.D. (M. D. or other) 1
Address 6815 W. Florissant Date signed 10/9/39

PHYSICIAN
Underline the cause to which death should be charged statistically

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.