

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.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

37889

Do not use this space.

## 1. PLACE OF DEATH

(a) County St. Louis Registration District No. 2  
(b) Township 1 Primary Registration District No. \_\_\_\_\_ Registered No. 9728  
(c) City St. Louis Mo (d) Street No. 4203 & No 20th St St. \_\_\_\_\_  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

## 2. PRINT FULL NAME

(a) Residence, No. 4203 & No 20th St St. 9 (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widow</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Tennis Walsh</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>6-2-1874</u>		
7. AGE YEARS <u>65</u>	MONTHS <u>5</u>	DAYS <u>12</u>
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.		If LESS than 1 day, ..... hrs. or ..... min.
9. Industry or business in which work was done, as saw mill, bank, etc.		
10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ireland</u> <u>5</u>		
13. NAME <u>Teremiah Regan</u> <u>5</u>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ireland</u> <u>5</u>		
15. MAIDEN NAME <u>Mrs Flanagan</u>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ireland</u>		
17. INFORMANT (ADDRESS) <u>Mrs Mary Walsh</u> <u>4203 &amp; No 20th St</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Cabron</u> DATE <u>11/16</u> <u>39</u>		
19. FUNERAL DIRECTOR (ADDRESS) <u>SULLIVAN</u> <u>2849 3rd 20th St</u>		
20. EMER <u>NOV 15 1939</u> Local Registrar.		

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 14 1939

22. I HEREBY CERTIFY, That I attended deceased from Oct 1 1939, to Nov 14 1939. I last saw her alive on Nov 13 1939. Death is said to have occurred on the date stated above, at 6 am m. The principal cause of death and related causes of importance were as follows:  
Cerebral Hemorrhage Date of onset \_\_\_\_\_

Other contributory causes of importance:  
arterio-sclerosis

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? no  
If so, specify Arterio-sclerosis, M. D.  
(Signed) \_\_\_\_\_ (Address) 340 3rd 14

**STATEMENT BY LICENSED EMBALMER**

I, \_\_\_\_\_, Licensed Embalmer No. \_\_\_\_\_  
hereby certify that the body recorded on the reverse side of this certificate was embalmed by Albert Maffield  
\_\_\_\_\_  
L. E. \_\_\_\_\_  
No. \_\_\_\_\_ or by \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.  
Signed Albert Maffield  
Licensed Embalmer No. 3077

**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.)**