

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

State File No. _____

927
927

Registration District No. _____

791

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(c) Name of hospital or institution: Carroll City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME James Duffy

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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 11/12-1891
(Month) (Year)

8. AGE: Years 48 Months 1 Days 16
If less than one day _____ hr. _____ min.

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

10. Usual occupation Cook

11. Industry or business _____

12. Name Lawrence Duffy

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

14. Maiden name Anna Duffy

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

16. (a) Informant's own signature Betty Duffy
(b) Address 249 N. Euclid

17. (a) Burial (b) Date thereof 1-31-40
(Burial, cremation, or removal) (Month) (Day) (Year)

18. (a) Signature of funeral director Sullivan
(b) Address 249 N. Euclid

19. (a) JAN 30 1940 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County _____
(c) City or town St. Louis 25
(If outside city or town limits, write "RURAL")
(d) Street No. 314 Clark
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 28
year 1940 hour 10 minute 30 P.M.

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

Immediate cause of death _____ Duration _____

Chronic Fibrosis

Due to Myocarditis with

Due to some Delation

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

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

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 Joseph M. Sullivan (M.D. or other) _____

Address 249 N. Euclid Date signed _____

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.

I X 10311

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. me
working under my personal supervision.

Signed Al Springfield
Licensed Embalmer No. 2077
P. O. Address.....

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.