

WRITE PLAINLY—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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3831
Registrar's No. 55

JAN 15 1940

Registration District No. 784

Primary Registration District No. 115

1. PLACE OF DEATH:

(a) County Mo. St. Louis Co.

(b) City or town UNIVERSITY CITY

(c) Name of hospital or institution:
7122 STANFORD AVE
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____

(c) City or town UNIVERSITY CITY
(If outside city or town limits, write "RURAL")

(d) Street No. 7122 STANFORD AVE
(If rural, give location)

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

3. (a) PRINT FULL NAME EDWARD SYLVESTER DALY

3. (b) If veteran, name war _____

3. (c) Social Security No. 492-03-5720

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 7 year 1940 hour 10 minute 40 P. M.

21. I hereby certify that I attended the deceased from Feb. 11, 1938 to Jan 7, 1940 that I last saw him alive on Jan 2, 1940 and that death occurred on the date and hour stated above.

4. Sex MALE 5. Color or race WHITE

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

6. (b) Name of husband or wife MINNIE HESSEL DALY

6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased MARCH 8, 1873
(Month) (Day) (Year)

Immediate cause of death Cerebral Hemorrhage (apoplexy) Duration 1 Day

Due to _____

Due to Hypertension 2 yrs

Other conditions None

8. AGE: Years 66 Months 9 Days 29 If less than one day _____ hr. _____ min.

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

10. Usual occupation FOREMAN - ELECTROTYPE DEPT

11. Industry or business WOODWORD TIERNAN PTC CO D

MOTHER FATHER { 12. Name JOHN DALY

18. Birthplace CANADA (City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name UN KNOWN

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

16. (a) Informant's own signature Minnie Dalry

(b) Address 7122 STANFORD AVE

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN. 10, 1940 (Month) (Day) (Year)

(c) Place: burial or cremation GALVARY

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

(b) Address 5165 DELMAR BLVD. APT 4

19. (a) JAN 9 - 1940 (Date received local registrar) (b) W. D. [Signature] (Registrar's signature)

Major findings: of 2a1

Of operations _____

Of autopsy no

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 Norman L. Trotter (M. D. or other) 1

Address 2725 N. W. St Date signed 1-8-40

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 *Howard Robinson*

Licensed Embalmer No. *3114*

P. O. Address *Ammon*

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.