

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.

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 2673

1. PLACE OF DEATH:

(a) County St. Louis, Missouri
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: City Sanitarium
(If not in hospital or institution, write street number or location) 1
(d) Length of stay: In hospital or institution 2 yrs. 2 mos. 12 days
In this community 34 yrs. 16 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis, Mo. 1-2
(If outside city or town limits, write "RURAL")
Street No. 1202 Aubert Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME James Walsh

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

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Sgl

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

7. Birth date of deceased March 5, 1906
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
34 16 16 _____ hr. _____ min.

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

10. Usual occupation Stone Mason

11. Industry or business _____

MOTHER FATHER { 12. Name Patrick Walsh
13. Birthplace Unknown Ireland
(City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name Cecelia Sheedy Walsh
15. Birthplace St. Louis, Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature John Walsh
(b) Address 5400 Grand

17. (a) Burial (b) Date thereof Mar/23, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery.

18. (a) Signature of funeral director Arthur J. Brennan
(b) Address 3840 Lindell Blvd

19. (a) MAR 22 1940 (b) J. J. Brennan
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 21st.
year 1940 hour 8:25 minute a.m. M.

21. I hereby certify that I attended the deceased from 7-1- 1939, to March 21, 1940
and that death occurred on the date and hour stated above.
that I last saw him alive on March 21, 1940

Immediate cause of death _____
Infarcts in Lungs from possible
Intra Cardiac Thrombus
Due to 3-21-40x
Chronic Myocarditis
Due to 2-19-40x

Duration

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

Major findings: _____
Of operations _____
Of autopsy Yes
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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 W. H. ... M. D. (M. D. or other)
Address 5400 Grand Date 3-21-40

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 S Marshall

Licensed Embalmer No. 2868

P. O. Address 3840 Lunde

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.