

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.

MAY 15 1940

Registration District No.

791

Primary Registration District No.

1003

State File No.

Registrar's No.

3234

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Bayard & Easton  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community 40 Yrs  
years, months or days

3. (a) PRINT FULL NAME Cornelius Aylward 463

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

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

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

7. Birth date of deceased Oct 16th, 1874  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
65 5 19 hr. min.

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

10. Usual occupation Letter Carrier Supervisor

11. Industry or business \_\_\_\_\_

12. Name James Aylward

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

14. Maiden name Johanna Roche

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

16. (a) Informant's own signature Charlotte Aylward

(b) Address 4939 Genevieve Ave

17. (a) Burial (b) Date thereof 4/9/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cent

18. (a) Signature of funeral director Harrigan & Sheehan Und Co

(b) Address 4415 Washington Blvd.

19. (a) APR 8 1940 (b) J. F. Bedech  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County \_\_\_\_\_  
(c) City or town St. Louis 7  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4939 Genevieve Ave.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. Life years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 5th  
year 1940 hour 2:45 PM minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from July 1935 to April 5, 1940  
that I last saw him alive on April 4, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death: Acute Dehydration of Heart. Duration \_\_\_\_\_

Due to Irregular Rhythm 5 yr  
Blow 2 yr

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 J. F. Bedech (M. D. or other) \_\_\_\_\_

Address 1878 Madison Date signed 4 5 40

Dr. Strissell  
19th & Madison

**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 Homer W. Fritz  
Licensed Embalmer No. 3882  
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.**