

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

16152

State File No. _____

Registration District No. 784

Primary Registration District No. 200

Registrar's No. 827

1. PLACE OF DEATH:

(a) County St. Louis.
(b) City or town Wellston, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Vincent Sanitarium.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 65 Years.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____
(c) City or town St. Louis.
(If outside city or town limits, write "RURAL")
(d) Street No. 5301 Page Blvd.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 27
year 1940 hour 7:30 minute A M.
21. I hereby certify that I attended the deceased from April 22
1940 to 4-27 1940
that I last saw her alive on 4-26 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar pneumonia
Due to _____
Due to _____

Other conditions Chronic Myocarditis
Arteriosclerosis
Major findings: _____
Of operations _____
Of autopsy _____

Duration

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. C. Mason (M. D. _____)
Address 7301 Natural Bridge Date signed 4/27/40

3. (a) PRINT FULL NAME Sister Hilary
(b) If veteran, name war _____ (c) Social Security No. _____

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

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

7. Birth date of deceased October 8, 1857
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
82 6 19 hr. min.

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

10. Usual occupation Religious.

11. Industry or business _____

12. Name Daniel McGreever.

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

14. Maiden name Mary Dont Know.

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

16. (a) Informant Sister Remigius
(b) Address 5301 Page Blvd

17. (a) Burial (b) Date thereof 4-29-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Arthur J. Donnelly

(b) Address 3840 Lindell Blvd

19. (a) APR 27 1940 (b) W. R. Mason
(Date received local registrar) (Registrar's signature)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

JUN 13 1944

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 Stanley Marshall

Licensed Embalmer No. 2868

P. O. Address. 3840 Lindell

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.