

Registration District No. **7911**

Primary Registration District No. **1002**

Registrar's No. **3984**

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

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. John's 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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis **25**
(If outside city or town limits, write "RURAL")
(d) Street No. 210 No. 17th. St.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Patrick Dowling **456**

3. (b) If veteran, name war No. 3. (c) Social Security No. None

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

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

7. Birth date of deceased June 5 1860
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
79 10 24 _____ hr. _____ min.

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

10. Usual occupation Retired

11. Industry or business

MOTHER FATHER { 12. Name Unknown Dowling **5**
13. Birthplace Ireland
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Della Luinetti

(b) Address 210 No. 17th. St.

17. (a) Burial (b) Date thereof 5-3-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetary

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Ave.

19. (a) MAY 1 1940 (b) J.F. Fischer
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 29
year 1940 hour 5 minute 45 P. M.

21. I hereby certify that I attended the deceased from April 9 - 1940 to April 29 1940
that I last saw him alive on April 29 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis
Uremia caused by chronic nephritis
Due to Senility
Due to 151
Other conditions (Include pregnancy within 3 months of death)

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 Charles Montani (M. D. or other) M.D.
Address 1926 N. Marconi Ave Date signed 5-1-40

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

Albert G. Hoff

Licensed Embalmer No.

2971

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.