

No. 2  
-10-39  
7-39  
X21

FILED JUN 15 1940 791  
Registration District No. \_\_\_\_\_

Primary Registration District No. 1003

State File No. \_\_\_\_\_  
Registrar's No. 4120

1. PLACE OF DEATH:  
(a) County \_\_\_\_\_  
(b) City or town St. Louis.  
(c) Name of hospital or institution: De Paul Hospital.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 Weeks.  
In this community 55 Years.  
years, months or days

8. (a) PRINT FULL NAME Cassie E. Farrington. 1652  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow.  
6. (b) Name of husband or wife Patrick J. Farrington 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased. August, 2, 1860  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
79 9 4 hr. \_\_\_\_\_ min.

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

10. Usual occupation At Home.

11. Industry or business \_\_\_\_\_  
12. Name Michael O'Neill.  
13. Birthplace Ireland. (City, town, or county) (State or foreign country)  
14. Maiden name Ellen Dooley.  
15. Birthplace Ireland. (City, town, or county) (State or foreign country)

16. (a) Informant Miss Guss Farrington  
(b) Address 1144 Hamilton Ave.

17. (a) Burial (b) Date thereof 5-9-40  
(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) MAY 8 1940 (b) J. P. [Signature]  
(Date received local Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County \_\_\_\_\_  
(c) City or town St. Louis, Mo. (If outside city or town limits, write "RURAL.")  
(d) Street No. 1144 Hamilton Ave (If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 6th.  
year 1940 hour 1 minute 35 P.M.

21. I hereby certify that I attended the deceased from April 14 1940  
to May 6 1940  
that I last saw her alive on May 6 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Pulmonary Edema Duration 2-3 days

Due to Ch. Myocarditis Chronic  
arteriosclerosis Chronic

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

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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 plant)  
(e) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) [Signature]  
Address [Signature] Date signed 5/7/40

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

MOTHER FATHER

W. O. P.  
4968  
Belmont Park  
F04350  
11-2-88  
7-8

**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 W. F. Van Matre  
Licensed Embalmer No. 2825  
P. O. Address 4340 Lafayette

**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.**