

No. 2  
11-10-39  
5-17-39  
I X21492

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

20312

State File No.

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 5250

FILED JUL 17 1940

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town ST. LOUIS  
(c) Name of hospital or institution:  
4905 HOOKE AVE.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 60 YEARS  
In this community \_\_\_\_\_  
years, months or days) (Specify whether \_\_\_\_\_)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County \_\_\_\_\_  
(c) City or town ST. LOUIS  
(If outside city or town limits, write "RURAL") 7  
(d) Street No. 4905 HOOKE AVE.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? 60 years.

3. (a) PRINT FULL NAME BRIDGET MAXWELL 240

3. (b) If veteran, name war \_\_\_\_\_ 3. (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 MAXWELL 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased UNKNOWN 1869  
(Month) (Day) (Year)

8. AGE: Years 71 Months UNKNOWN Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation AT HOME

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

12. Name RICHARD McDONOUGH

13. Birthplace IRELAND

14. Maiden name MARY SULLIVAN

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

16. (a) Informant MRS. JAMES NOONAN

(b) Address 4905 HOOKE AVE.

17. (a) BURIAL (b) Date thereof 6-18-40  
(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) JUN 17 1940 (b) J. F. Bredenk  
(Date received local registrar) (Registrar's signature)

MOTHER FATHER

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JUNE day 15,  
year 1940 hour 5 minute 20 P. M.

21. I hereby certify that I attended the deceased from 4/6/40  
6-15-40, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw her alive on 6-15-40  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Interstitial Nephritis  
Due to \_\_\_\_\_

Due to None  
Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operation \_\_\_\_\_  
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 Dr. Schaper (M. D. or other)  
Address 901 University Club Date signed 6/16/40

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

**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 William Matre  
Licensed Embalmer No. 2825  
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.**