

ED AUG 25 1940
Registration District No. **791**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **St. Louis**
(c) Name of hospital or institution **2926 No Euclid**
(d) Length of stay: In hospital or institution _____
In this community _____
years, months or days

3. (a) PRINT FULL NAME **JULIA MAHONEY**

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

4. Sex **F**
5. Color or race **W**
6. (a) Single, widow, married, divorced, **Widow**
6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **2-21-1868**
(Month) (Day) (Year)

8. AGE: Years **72** Months **5** Days **11**
If less than one day _____ hr. _____ min.

9. Birthplace **Ireland** (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

MOTHER FATHER { 12. Name **Joseph O'Leary**

18. Birthplace **Ireland**

14. Maiden name **Elizabeth O'Leary**

15. Birthplace **Ireland**

16. (a) Informant **Hell M. Mahoney**

(b) Address **2926 No Euclid Ave**

17. (a) **Burial** (b) Date thereof **7-16-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Galvan Cemetery**

18. (a) Signature of funeral director **Sullivan Bros**
(b) Address **2849 No Euclid Ave**

19. (a) **JUL 15 1940** (Date received local registrar)
J. F. Bredeck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
(c) City or town **St. Louis**
(d) Street No. **2926 No Euclid Ave**
(e) If foreign born, how long in U. S. A.? **60 years**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **13**
year **1940** hour **4** minute **2** M.

21. I hereby certify that I attended the deceased from **March 11, 1930**, to **July 13, 1940**
that I last saw her alive on **July 12, 1940**, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary congestion**
hypoglycemic
Due to **can cause of heart**

Due to **Edema of face - all limbs**
lungs

Other conditions (Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: Of operations _____
Of autopsy _____
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. W. White** (M. D. or other) **M.D.**
Address **2803 N. Sanghae St** Date signed **7-13-40**

Dr. W. H. ...

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 Mayfield*
Licensed Embalmer No. 3077
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.