

BUREAU OF THE CITY
AUG 25 1940

State File No. _____

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 5967

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

1. PLACE OF DEATH:

(a) County _____
(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. Anthony's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1
(Specify whether
In this community 30 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County _____
(c) City or town St. Louis 15th
(If outside city or town limits write "RURAL")
(d) Street No. 5528 Tennessee
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 15
year 1940 hour _____ minute 11¹⁵ A. M.

21. I hereby certify that I attended the deceased from May 1
_____ 1940 to July 15, 1940
that I last saw her alive on July 15th, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma of Bladder - Urinary
Due to _____

Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy: Carcinoma of Bladder - Pyelonephritis

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: Chas E. Sista (M. D. or other) M.D.
Address 1113 Paul Brown Bldg Date signed 7/16/40

3. (a) PRINT FULL NAME Mary A. Lax and

8. (b) If veteran, name war no 3. (c) Social Security No. none

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

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

7. Birth date of deceased August 12, 1864
(Month) (Day) (Year)

8. AGE: Years 75 Months 11 Days 3 If less than one day _____ hr. _____ min.

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

10. Usual occupation none

11. Industry or business _____

12. Name Michel Rooney 51

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

14. Maiden name Catherine Duffy

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

16. (a) Informant Wm A. Lax

(b) Address 5528 Tennessee

17. (a) Burial (b) Date thereof 7-18-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Park Lawn Cem

18. (a) Signature of funeral director Stephen J. Brand

(b) Address 6327 S Grand

19. (a) JUL 16 1940 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

*Dr. Sexton
Paul Brown Bldg*

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 *Frank Ludwig*
Licensed Embalmer No. *2504*
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.