

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

FILED SEP 25 1940

Registration District No. **791**

Primary Registration District No. **1003**

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: _____
4957 a Rosalie **2**
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)
 In this community _____

3. (a) PRINT FULL NAME Ellen M. Delaney **450**
 (b) If veteran, name war _____ (c) Social Security No. None

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Frank T. Delaney
 6. (c) Age of husband or wife if alive 46 years
 7. Birth date of deceased Feb 14 1894
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
46 5 18 hr. min.

9. Birthplace St. Louis, Mo. Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation housewife

11. Industry or business _____

MOTHER FATHER
 { 12. Name James E. Flynn
 { 13. Birthplace St. Louis Co. Missouri
(City, town, or county) (State or foreign country)
 { 14. Maiden name Mary Larkin
 { 15. Birthplace St. Louis Co. Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Frank T. Delaney
 (b) Address 4957 a Rosalie

17. (a) Burial (b) Date thereof Aug 8, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Valhalla

18. (a) Signature of funeral director Chas. J. Nixon Funeral Home
 (b) Address 4911 Washington, Blvd.

19. (a) AUG 3 1940 (b) J. P. Debecke
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
 (c) City or town St. Louis
(If outside city or town limits, write "RURAL")
 (d) Street No. 4957a Rosalie **7**
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 1st
 year 1940 hour 9 minute _____ P. A. M.

21. I hereby certify that I attended the deceased from July 5th 1940 to Aug 1st 1940
 that I last saw alive on Aug 1st 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Artery Thrombosis. **27 days**
 Due to _____
 Due to _____

Other conditions None
(Include pregnancy within 3 months of death)

Major findings: _____
 Of operations _____
 Of autopsy None made

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)
 (a) Means of injury _____

28. Signature Joseph Davis (M. D. or other) M.D.
 Address Century Bldg Date signed 8-2-40

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 *Thomas H. Fenwick*

Licensed Embalmer No. *3793*

P. O. Address *St. Louis, Mo.*

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.