

No. 2
1-10-39
17-39
X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 30343

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 7620

RECEIVED OCT 26 1940

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Mary's Infirmary
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis 18
(If outside city or town limits, write "RURAL")
(d) Street No. 103 South Channing
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME

Mary Quinn

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Female

5. Color or race Colored

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Fred Quinn

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased December 25, 1874
(Month) (Day) (Year)

8. AGE: Years 55 Months 8 Days 14 If less than one day hr. _____ min. _____

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

10. Usual occupation Housework

11. Industry or business _____

12. Name Pete. Blumenthal

18. Birthplace MISS.
(City, town, or county) (State or foreign country)

14. Maiden name Lucy Jones

16. Birthplace MISS.
(City, town, or county) (State or foreign country)

16. (a) Informant Fred Quinn

(b) Address 103 S. Channing

17. (a) Burial (b) Date thereof 9/11/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park Cem

18. (a) Signature of funeral director Russell Uhd Co.

(b) Address 2732 Pine St

19. (a) SEP 11 1940 (b) _____
(Date received for registration) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 11th 9th
year 1940 hour 3 minute 40 A. M.

21. I hereby certify that I attended the deceased from September 6th 1940 to September 9, 1940; that I last saw her alive on September 9, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Coma
Due to Diabetes 59
Due to _____

Other conditions Cholelithiasis left femur
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy Nephrosclerosis, c.P. of lung & liver

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 _____
Signature Wm. Sinkler (M. D. or other) MD
Address 1536 Pine St Date signed 9-10-40

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

MOTHER FATHER

PHYSICIAN
Underline the cause to which death should be charged statistically.

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 Joel Russell

Licensed Embalmer No. 4112

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.