

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

NOV 16 1940

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:  
3225 No. Florissant Ave. 2  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 1/2 Years.  
(Specify whether years, months or days)

In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Thomas Cummins.

8. (b) If veteran, name war \_\_\_\_\_

8. (c) Social Security No. None

4. Sex. Male

5. Color or race White

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

6. (b) Name of husband or wife Josephine Cummins.

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

7. Birth date of deceased. July 4, 1865  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>75</u>	<u>3</u>	<u>7</u>	hr. _____ min.

9. Birthplace Ireland. 5  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Engineer. 5

11. Industry or business \_\_\_\_\_ 9

MOTHER FATHER

12. Name Williams Cummins. 9

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

14. Maiden name Statia Baren.  
(City, town, or county) (State or foreign country)

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

16. (a) Informant Sister Jeanne.

(b) Address 3225 No. Florissant Ave.

17. (a) Burial (b) Date thereof 10-14-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director John J. Donnelly

(b) Address 3840 Lindell Blvd

19. (a) OCT 12 1940 (b) \_\_\_\_\_  
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County \_\_\_\_\_

(c) City or town St. Louis. 20  
(If outside city or town limits, write "RURAL")

(d) Street No. 3225 No. Florissant Ave.  
(If rural, give location)

(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 11  
year 1940 hour 5:30 minute A M.

21. I hereby certify that I attended the deceased from May 10, 1940 to Oct. 11, 1940  
that I last saw him alive on Oct. 11, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Right Maxilla (1 month) 5 months

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: W/S

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 Anthony A. Bekorski M.D.  
Address 1525 Cass Ave Date signed 10/13/40  
(M. D. or other)

**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 *Stanley Marshall*

Licensed Embalmer No. *2868*

P. O. Address *3840 Lindell Blvd*

**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.**