No. 2
11-10-39

FILED DEC 11 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

1003

State File No. 36738

Registration District No. 791 · Primary Registration District No. ______ Registrar's No. 9011

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

1. PLACE OF DEATH:
(a) County St Louis Mo 3
(b) City or town ______ (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Little Sisters of Poor 23rd + Hebert
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ______ In this community ______ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED: 0
(a) State St Louis (b) County Mo 20
(c) City or town 23rd + Hebert St (If outside city or town limits, write "RURAL")
(d) Street No. Little Sisters of Poor (If rural, give location)
(e) If foreign born, how long in U. S. A.? ______ years.

3. (a) PRINT FULL NAME Michael Cronin
3. (b) If veteran, name war ______ 3. (c) Social Security No. ______

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife ______ 6. (c) Age of husband or wife if alive ______ years

7. Birth date of deceased 3-21-1874 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
66	7	10	___ hr. ___ min.

9. Birthplace Ireland (City, town, or county) (State or foreign country) 5
10. Usual occupation Labor 5
11. Industry or business ______

FATHER
12. Name Michael Cronin 5
13. Birthplace Ireland (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mgt Nealy
15. Birthplace Ireland (City, town, or county) (State or foreign country)

16. (a) Informant David Cronin
(b) Address 5135 Robin Ave
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-4-40 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cem
18. (a) Signature of funeral director Sullivan Bros
(b) Address 2849 No Euclid
19. (a) NOV 1 1940 (Date received local registrar) (b) J. F. Bredbeck (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 31 year 1940 hour 2 minute 30 P M.
21. I hereby certify that I attended the deceased from Oct 1, 1940 to Oct 31, 1940 that I last saw him alive on Oct 31, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic Myocarditis	2 Mos
Due to ______	
Due to ______	
Other conditions Arteriosclerosis (Include pregnancy within 3 months of death)	
Major findings: 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? ______ (Specify type of place)
While at work? ______ (e) Means of injury ______

23. Signature Anthony J. Piekarski (M. D. or other) M.D.
Address 1525a Cass Ave Date signed 11/1/40

(Licensed Embalmer's Statement on Reverse Side)

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 Al 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 w the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.