No. 2
—1-4-41
5-17-39
I X25390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

FILED OCT 18 1941

State File No. 29922

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. 7261

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: De Paul Hospital.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 11 Days. (Specify whether years, months or days)

In this community 21 Years.

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 96

(c) City or town ~~St. Louis.~~ Wellston N.R. 0
(If outside city or town limits, write "RURAL") 0

(d) Street No. 2700 Normandy Drive.
(If rural, give location)

(e) Citizen of foreign country? / (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Sister M. Alphonsus. (Brigid Delaney)

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

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 November (Month) 28 (Day) 1899 (Year)

8. AGE: Years 41 Months 9 Days 9 If less than one day hr. min.

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

10. Usual occupation Teacher.

11. Industry or business

FATHER
12. Name Unknown Delaney.
13. Birthplace Ireland. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Not Known.
15. Birthplace Ireland. (City, town, or county) (State or foreign country)

16. (a) Informant Sr. M. Luitgardis.
(b) Address 2700 Normandy Drive.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-9-41 (Month) (Day) (Year)
(c) Place: burial or cremation Incarnate Word Cemetery.

18. (a) Signature of funeral director Arthur J. Donnelly
(b) Address 3840 Lindell Blvd

19. (a) SEP 8 1941 (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 7th year 1941 hour 8 minute 55 P.M.

21. I hereby certify that I attended the deceased from June 4, 1941, to September 7, 1941; that I last saw her alive on Sept 7, 1941; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cancer of Duodenum	1 yr
Due to: Operation abdominal 9-3-41	4 da
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations: Obstruction to pyloric evacuation by post peritoneal carcinoma glands. Of autopsy: Cancer Duodenum (Ampulla of Vater)	

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 John C. Morfit (M. D. or other) D
Address 940 Ry. Bld 634 N. Grand Date signed 9-8-41

(Licensed Embalmer's Statement on Reverse Side)

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

1-11
Page 1 of 2

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 W H Van Matre

Licensed Embalmer No. 2825

P. O. Address 4340 Lafayette

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, fact should be so stated above.

. S. No. 2B
M—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 29922

Registration District No. 791 Primary Registration District No. 1003 Registrar's No.

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:
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County
(c) City or town
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Sister M. Alphonsus (Brigid Delany)

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Nov 28 1898
(Month) (Day) (Year)

8. AGE: Years 41 Months 9 Days 6 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

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

16. (a) Informant
(b) Address

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

18. (a) Signature of funeral director
(b) Address

19. (a) NOV 21 1941 (Date received by registrar) (b) J. F. Brecht (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day
year 1941 hour minute M.

21. I hereby certify that I attended the deceased from
19 to 19;
that I last saw him alive on 19;
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Due to	
Due to	
Other conditions (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 (M. D. or other)
Address Date signed

SUPPLEMENTARY