

FILED FEB 24 1947 91

Registration District No. \_\_\_\_\_

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: **Desloge Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **9-days**  
In this community **8-years**  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County \_\_\_\_\_  
(c) City or town **St. Louis**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **2615a Marcus Ave.**  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **James R. Walsh**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

4. Sex **M.** 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 **March 4th., 1917**  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<b>24</b>	<b>10</b>	<b>12</b>	hr. _____ min. _____

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

10. Usual occupation **Dental Student**

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

MOTHER FATHER { 12. Name **Richard Walsh**

13. Birthplace **St. Louis Mo. /**  
(City, town, or county) (State or foreign country)

14. Maiden name **Loretto O'Brien**

15. Birthplace **St. Louis Mo. /**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mr. Richard Walsh**  
(b) Address **2615a Marcus Ave.**

17. (a) **Burial** (b) Date thereof **1-19-47**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Cemetery**

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

19. (a) **JAN 17 1947** (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan.** day **16th.,**  
year **1947** hour **6** minute **50** a. m.

21. I hereby certify that I attended the deceased from **Jan 6th** 19**47** to **Jan 16** 19**47**  
that I last saw him alive on **Jan 15,** 19**47**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Septicemia** Duration **7 1/2 / 47**

Due to **Chronic Glomerulonephritis with Hypertension** } **1 year**

Other conditions **Pneumonia, Heart Disease, not fatal**

Major findings: Of operations \_\_\_\_\_ Of autopsy **None**

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 **J. P. Brennan M.D.** (M. D. or other) \_\_\_\_\_  
Address **5099 Grand Blvd.** Date signed **1/16/47**

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

266

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

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, fact should be so stated above.