

S. No. 2
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5-17-39
WI X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILE AUG 14 1942 791
Registration District No. 791

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
Primary Registration District No. 1003

State File No. 23034
Registrar's No. 6496

1. PLACE OF DEATH:
(a) County St. Louis Mo.
(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:
634 So. Newstead ave / (Morgue)
(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 000
(c) City or town St. Louis Mo. (If outside city or town limits, write "RURAL") 12
(d) Street No. 4946 Labadie ave (If rural, give location) 96
(e) Citizen of foreign country? _____ (Yes or No) _____
No Attending Physician
Usual home country _____

3. (a) PRINT FULL NAME William J Quinn
(b) If veteran, name war _____
(c) Social Security 409-14-2557

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 31
year 1942 hour 4 minute 15PM M.
21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____
that I last saw h _____ alive on _____ 19____
and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W
6. (a) Single, widowed, married, divorced Married
(b) Name of husband or wife Margaret Quinn
(c) Age of husband or wife if alive 65 years
7. Birth date of deceased 5/12/1871
(Month) (Day) (Year)

Immediate cause of death Arteriosclerosis
Chronic Hepatitis
Adhesive Pericarditis
Other conditions _____
(Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy _____
Duration _____

8. AGE: Years 71 Months 2 Days 19 If less than one day _____ hr. _____ min.

9. Birthplace Ireland (City, town, or county) (State or foreign country) 4

10. Usual occupation Mechanist

11. Industry or business Ludlow & saylor Wire Co.

MOTHER FATHER
12. Name Wm P QUINN
13. Birthplace IRELAND 4 (City, town, or county) (State or foreign country)
14. Maiden name DON'T KNOW
15. Birthplace IRELAND 4 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Margaret Quinn
(b) Address 4946 Labadie ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/3/42 (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cem.

18. (a) Signature of funeral director SULLIVAN BRO'S
(b) Address 2849 N. Euclid ave.

19. (a) J. F. Bredesh (Date received local registrar's certificate) (b) J. F. Bredesh (Registrar's signature)

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 3
23. Signature Wm P Quinn (M. D. or other) _____
Address _____ Date signed 8/1/42

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

000
12
9

B

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..... *Alton Mayfield*.....
Licensed Embalmer No. *3077*.....
P. O. Address *St. Louis Mo*.....

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.