

FILED JUN 25 1943

Primary Registration District No. 1003

Registrar's No.

1. PLACE OF DEATH:

(a) County.....
 (b) City or town..... **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Louis City Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution..... **15 Days**
(Specify whether
 In this community.....
years, months or days)

3. (a) PRINT FULL NAME **Daniel Mullarky**

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex..... **M** 5. Color or Race..... **W** 6. (a) Single, widowed, married, divorced..... **married**
 6. (b) Name of husband or wife..... **Mary Ferguson** 6. (c) Age of husband or wife if alive..... years
 7. Birth date of deceased..... **August 27 1864**
(Month) (Day) (Year)

| 8. AGE: | Years | Months | Days | If less than one day |
|---------|-------|--------|------|----------------------|
| | 78 | 9 | 18 | hr. min. |

9. Birthplace..... **Ireland** 4
(City, town, or county) (State or foreign country)10. Usual occupation..... **Salesman**11. Industry or business..... **Laclede Gas**

MOTHER FATHER { 12. Name..... **Mullarky (Unknown)**
 13. Birthplace..... **Ireland** 4
(City, town, or county) (State or foreign country)
 14. Maiden name..... **Unknown**
 15. Birthplace..... 9
(City, town, or county) (State or foreign country)

16. (a) Informant..... **John Mullarky**
(b) Address..... **5422 Devonshire**17. (a) **Burial** (b) Date thereof..... **6/18/43**
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation..... **Calvary Cem.**18. (a) Signature of funeral director..... **Sulligan Bros**(b) Address..... **2849 N. Euclid Ave.**19. (a) **JUN 16 1943** (b) (Registrar's signature)
(Date received local registration)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... **Mo** (b) County..... **15503**
 (c) City or town..... **St Louis** 14
(If outside city or town limits, write "RURAL")
 (d) Street No..... **5422 Devonshire Av.**
(If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... **June** day..... **15**,
year..... **1943** hour..... **2:18** minute..... **P.** M.21. I hereby certify that I attended the deceased from..... **June**
1, 19**43**, to..... **June 15**, 19**43**
that I last saw him alive on..... **June 15**, 19**43**
and that death occurred on the date and hour stated above.Immediate cause of death..... **Heart Deficiency** DurationDue to..... **Left Hemiplegia**Due to..... **Arteriosclerosis**Other conditions..... **83**
(Include pregnancy within 3 months of death)

Major findings: Of operations..... PHYSICIAN

Of autopsy..... **refused** 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..... **Dr. SALMON** (M. D. or other) **J.M.D.**
Address..... **1515 Lafayette Avenue,** Date signed..... **6/15/43**

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.....

Albert 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 with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.