

FILED AUG 8 1943

Registration District No. 218

Primary Registration District No. 1003

Registrar's No. 6281

1. PLACE OF DEATH:

(a) County ST. LOUIS, MO.
(b) City or town (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: CITY HOSPITAL, 0
(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 MO (b) County
(c) City or town ST LOUIS - 9/10
(If outside city or town limits, write "RURAL")
(d) Street No. 3525 FAIR AVE.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME MARY MANNION

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

4. Sex FEMALE
5. Color or race WHITE
6. (a) Single, widowed, married, divorced, widow
6. (b) Name of husband or wife MICHAEL MANNION.
6. (c) Age of husband or wife if alive - years
7. Birth date of deceased AUG. 15, 1868
(Month) (Day) (Year)

8. AGE: Years 74, Months 10, Days 24
If less than one day hr. min.

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

10. Usual occupation AT HOME

11. Industry or business

12. Name THOS. SHERIDAN.
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 Margaret Harrigan.

(b) Address 3525 FAIR AVE.

17. (a) BURIAL (b) Date thereof 7-12-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY.

18. (a) Signature of funeral director J. M. Mullen

(b) Address 5165 DELMAR BLVD.

19. (a) JUL 11 1943 J. J. Budeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 9th
year 1943 hour 1:10 PM minute P M.

21. I hereby certify that I attended the deceased from 6-30 1943 to 7-9-1943
that I last saw her alive on 7-9-1943
and that death occurred on the date and hour stated above.

Immediate cause of death
Hypertensive
cardiovascular disease 2 years

Due to Generalized arteriosclerosis

Due to 9/26

Other conditions Fracture of pelvis
(include pregnancy within 3 months of death)
acute psychosis, Dr. stated

Major findings: Of operations that fracture was not contributory
Of autopsy none contributory
Underline the cause to which death should be charged statistically.
cause

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 Home & Sweetman M.D.
Address 1515 Lafayette Date signed 7-9-43

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

MOTHER FATHER

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.....

William J. Heron

Licensed Embalmer No.....

4319

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.