

Registration District No. **116**

Primary Registration District No. **3020**

1. PLACE OF DEATH:

(a) County **Franklin Mo**
(b) City or town **Washington Mo**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **St. Francis Hospital**
(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) **11**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri**, (b) County **090**
(c) City or town **St. Louis** **17**
(If outside city or town limits, write "RURAL")
(d) Street No. **4036 Laclede** **9**
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) **1**
If yes, name country

3. (a) PRINT FULL NAME **Michael J. Quinlan**

3. (b) If veteran, name war **-** 3. (c) Social Security No. **492-05-0625**

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **9**

6. (b) Name of husband or wife **Anne Padgett** Age of husband or wife if alive, years **9**

7. Birth date of deceased: **8-23-1889**
(Month) (Day) (Year)

8. AGE: Years **54** Months **0** Days **15** If less than one day hr. min.

9. Birthplace **Jefferson City Mo** (City, town, or county) (State or foreign country) **0**

10. Usual occupation **Business Agt.**

11. Industry or business **Boot + shoe worker Union**

12. Name **-**

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

14. Maiden name **Mary**

15. Birthplace **Mo** (City, town, or county) (State or foreign country) **0**

16. (a) Informant **Albert Frank Jensen**

(b) Address **4036 Laclede**

17. (a) **Valdalla** (b) Date thereof **9-10-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Valdalla Cem. - St. Louis Mo**

18. (a) Signature of funeral director **G. Donnelly & Co**

(b) Address **3940 Linnell Blvd**

19. (a) **Sept 15 1943** (b) **Lucille Butler**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **8**
25 year **1943** hour **3:09** minute **A. M.**

21. I hereby certify that I attended the deceased from **Sept 4**
19 **43** to **Sept 8** 19 **43**
that I last saw him alive on **Sept 8** 19 **43**
and that death occurred on the date and hour stated above.

Immediate cause of death **acute myocarditis** **1 day**

Due to **cerebral congestion with hemorrhage** **4 days**

Due to **other conditions**
(Include pregnancy within 3 months of death)

Major findings: Of operations **1700-8**
Of autopsy **78**

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) **accident 036**

(b) Date of occurrence **Sept 4 1943**

(c) Where did injury occur? **Union Franklin Mo**
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
On Public Highway
While at work? **no** (Specify type of place) (e) Means of injury **auto**

23. Signature **Harvey H Schmidt** (M. D. or other) **MD**
Address **Marthasville, Mo** Date signed **9-8-43**

1151

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

MOTHER FATHER

36
26

VS
APR 23 1959

NOV 13 1949

OCT 18 1949
8 10 130

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

H. A. Van Mater

Licensed Embalmer No.....

P. O. Address.....

No
4050 Lafayette

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.