

ED JAN 3 1944

818

1003

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County St. Louis
 (b) City or town St. Louis
 (c) Name of hospital or institution 4820 Northland
 (d) Length of stay: In hospital or institution _____

In this community _____ years, months or days

3. (a) PRINT FULL NAME Delia Dunne

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

5. Color of race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Thomas 6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased 1878

8. AGE: Years 65 Months - Days - If less than one day _____

9. Birthplace Ireland

10. Usual occupation Housewife

11. Industry or business At Home

12. Name John Martin

13. Birthplace Ireland

14. Maiden name Bridget

15. Birthplace Ireland

16. (a) Informant Thomas Dunne

(b) Address 4820 Northland

17. (a) Burial, cremation, or removal Burial (b) Date thereof 12-22-43

(c) Place: burial or cremation Galway Park

18. (a) Signature of funeral director Caras F. Stuart

(b) Address 1225 Union Blvd.

19. (a) DEC 21 1943 (b) J. F. Bredak

(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis
 (c) City or town St. Louis
 (d) Street No. 4820 Northland
 (e) Citizen of foreign country? 0 (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 19
 year 1943 hour 12 noon minute _____ M.

21. I hereby certify that I attended the deceased from Dec 18 1943, to Dec 19 1943
 that I last saw him alive on Dec 18 1943
 and that death occurred on the date and hour stated above.

Immediate cause of death Subacute pneumonia Duration 2

Due to Cause unknown

Due to Ht.

Other conditions Secondary pneumonia 2
 (Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

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 Thomas Kave (M. D. or other)

Address 1117 N Grand Date signed 12/24/43

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

MOTHER FATHER

PHYSICIAN
 Underline the cause to which death should be charged statistically.

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 John Agonovski
Licensed Embalmer No. 3398
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.