

No. 2
2-43
17-39
X33697

Dr. Waage

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

328

FILED FEB 27 1944
318

State File No. _____

Registration District No. _____

1003

Registrar's No. 316

1. PLACE OF DEATH:

(a) County _____

(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: ST JOHN'S 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)

In this community _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County JEFFERSON

(c) City or town RURAL FUREKA RR#1
(If outside city or town limits, write "RURAL")

(d) Street No. (Byrnesville)
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME THOMAS DAVID DERRY

3. (b) If veteran, name war NONE

3. (c) Social Security No. NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 19 year 1944 hour 1 minute 18 P.M.

21. I hereby certify that I attended the deceased from Jan 4 1944, to Jan 10 1944; that I last saw him alive on Jan 10 1944; and that death occurred on the date and hour stated above.

4. Sex MALE 5. Color or race WHITE

6. (a) Single, widowed, married, divorced SINGLE

6. (b) Name of husband or wife NONE

6. (c) Age of husband or wife if alive NONE years

7. Birth date of deceased: SEPT 20 1880
(Month) (Day) (Year)

Immediate cause of death: Cardiac decompen- sation

Due to Hypertensive Cardio-vascular disease

Other conditions (Include pregnancy within 3 months of death) _____

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

63 3 20 hr. min.

9. Birthplace FUREKA RR#1 (BYRNESVILLE) MO
(City, town, or county) (State or foreign country)

10. Usual occupation FARM HAND

11. Industry or business FARMING

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

MOTHER FATHER

12. Name MARK DERRY

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

14. Maiden name MARGARET FARLEY

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

16. (a) Informant Bertha M Ober

(b) Address House Springs Mo RR#1

17. (a) BURIAL Removal (Burial, cremation, or removal) Date there JAN 13-1944
(City or town) (County) (State)

(c) Place: burial or cremation ST COLUMBIANS - CEM.

18. (a) Signature of funeral director John J. Brumby

(b) Address House Springs Mo

19. (a) JAN 14 1944 (b) J. H. Brudeck
(Date received local registration) (Registrar's signature)

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)

Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____
(Specify type of place) (c) Means of injury

23. Signature Charles F. Wilson (M. D. or other) M.D.
Address St. Louis Hospital Date signed 1-11-44

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

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 *Howard B. Rowland*

Licensed Embalmer No. *2114*

P. O. Address *St*

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.