S. No. 2
M—5-43
. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 1 1944

Registration District No.

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 5243

Registrar's No. ~~1793~~ 000

1. PLACE OF DEATH:

(a) County

(b) City or town ST. LOUIS
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 4031 WINNEBAGO ST. /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community 50 YEARS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County

(c) City or town ST?. LOUIS
(If outside city or town limits, write "RURAL")

(d) Street No. 4031 WINNEBAGO ST.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME CATHERINE HESSION

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 2

6. (b) Name of husband or wife PATRICK HESSION

6. (c) Age of husband or wife if alive years

7. Birth date of deceased UNKNOWN (Month) (Day) 1874 (Year)

8. AGE: Years 70 Months UNKNOWN Days If less than one day hr. min.

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

10. Usual occupation AT HOME

11. Industry or business

FATHER
12. Name MICHAEL QUINN
13. Birthplace (City, town, or county) IRELAND 4 (State or foreign country)

MOTHER
14. Maiden name ANN QUINN (NEE)
15. Birthplace (City, town, or county) IRELAND 4 (State or foreign country)

16. (a) Informant TOM HOWE
(b) Address 4031 WINNEBAGO ST.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2-25-44 (Month) (Day) (Year)
(c) Place: burial or cremation CALVARY CEMETERY

18. (a) Signature of funeral director Arthur J Donnelly
(b) Address 3840 Lindell Blvd

19. (a) FEB 23 1944 (Date received local registrar) (b) J. F. Budick (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month FEB. day 22
year 1944 hour 8 minute 10 A. M.

21. I hereby certify that I attended the deceased from Feb 1, 1944 to Feb 22, 1944
that I last saw her alive on Feb 21, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death auricular fibrillation and decompensation

Due to Has not been well for

Due to past 3 years

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

95 a

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)

(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? (Specify type of place)

While at work? (e) Means of injury

23. Signature J H Watson 0 (M. D. or other)

Address 536 N Taylor Date signed 2-22-44

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(Licensed Embalmer's Statement on Reverse Side)

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 W H Van Matre

Licensed Embalmer No. 2825

P. O. Address 4340 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.