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5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED MAR 1 1944

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **1612**

1. PLACE OF DEATH:  
(a) County **ST. LOUIS**  
(b) City or town **ST. LOUIS**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**LITTLE SISTERS POOR-3400 S. GRAND BLVD**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution..... (Specify whether  
In this community..... (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **MO** (b) County **000**  
(c) City or town **ST. LOUIS** (If outside city or town limits, write "RURAL") **17**  
(d) Street No. **2235 S. GRAND BLVD.** (If rural, give location) **917**  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME **JOSEPHINE Quinn**  
3. (b) If veteran, name war..... 3. (c) Social Security No.....

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **FEB.** day **16**  
year **1944** hour **7** minut **45** P. M.

4. Sex **FEMALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **WIDOW**  
6. (b) Name of husband or wife **JOHN W. QUINN** 6. (c) Age of husband or wife if alive..... years  
7. Birth date of deceased **DEC. 23, 1871**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **5** to **16** 19**44**  
that I last saw him alive on **FEB 16**, 19**44**  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
**72** **1** **23** hr. min.

Immediate cause of death **Coronary Occlusion**  
Due to **Arterio Sclerosis**  
Due to **Sclerosis**  
Other conditions (Include pregnancy within 3 months of death)  
Major findings: Of operations.....  
Of autopsy.....

9. Birthplace **ST. LOUIS MO.**  
(City, town, or county) (State or foreign country)  
10. Usual occupation **AT HOME**

11. Industry or business  
12. Name **PATRICK COMERFORD**  
13. Birthplace **IRELAND**  
(City, town, or county) (State or foreign country)  
14. Maiden name **MARGARET QUINLAN**  
15. Birthplace **IRELAND**  
(City, town, or county) (State or foreign country)

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) (b) Means of injury.....

16. (a) Informant **MRS. T. ED. ALBRIGHT**  
(b) Address **4000 RUSSELL AVE.**  
17. (a) **BURIAL** (b) Date thereof **2-19-44**  
(Burial, cremation, or removal) (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 18** 19**44** (b) **J. J. Bruders**  
(Date received local registrar) (Registrar's signature)

23. Signature **Arthur J. Donnelly** or other  
Address **3840 Lindell Blvd.** Date signed **2/17/44**

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

MOTHER FATHER

844

(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 Stanley Marshall

Licensed Embalmer No. 2868

P. O. Address 3840 Rindell

**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.**