

V. S. No. 2
100M-5-43
Rev. 5-17-39
I X36671

FILED AUG 8 1944

Registration District No. **318** Primary Registration District No. _____ Registrar's No. **6544**

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

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: St. Louis Childrens Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 6 hours
(Specify whether)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED: **979**

(a) State Illinois (b) County 11
 (c) City or town Chicago
(If outside city or town limits, write "RURAL")
 (d) Street No. 1619 West Garfield Blvd.
(If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country L

3. (a) PRINT FULL NAME TYRRELL, JACQUELINE ANN
 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 -0
 6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased 2-4-44
(Month) (Day) (Year)

8. AGE: Years _____ Month 5 Days 20
 If less than one day _____ hr. _____ min.

9. Birthplace Corvallis, Oregon
(City, town, or county) (State or foreign country)

10. Usual occupation child

11. Industry or business _____

MOTHER FATHER

12. Name John Tyrrell
 13. Birthplace Chicago, Ill.
(City, town, or county) (State or foreign country)

14. Maiden name Delores Jenisek
 15. Birthplace Chicago, Ill.
(City, town, or county) (State or foreign country)

16. (a) Informant G. de Manuele
 (b) Address 500 S. King Highway

17. (a) removal (b) Date thereof 7-25-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chicago, Illinois

18. (a) Signature of funeral director Alberta H. Hoppe
 (b) Address 4700 Washington Ave

19. (a) JUL 25 1944 G. F. Busack
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 24
 year 44 hour 4 minute 30 P. M.
 21. I hereby certify that I attended the deceased from 7-24-
1944 to 7-24- 1944
 that I last saw h. ER alive on 7-24- 1944
 and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial infarction
Secondary: possible cerebral
hemorrhage on scrobicula basis
 Due to _____

Due to _____
 Other conditions _____
(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)
 (2) Means of injury _____
 23. Signature R. J. Blatter (M. D. or other)
 Address 500 S. King Highway Date signed _____

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

844

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..... *Sheldon Collier*

Licensed Embalmer No..... *3382*

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.