

FILED DEC 9 1944
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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35843**
Registrar's No. **10113**

Registration District No. _____

Primary Registration District No. _____

1003

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:
3724 a Penrose 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 _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis,
(If outside city or town limits, write "RURAL")
(d) Street No. 3724 a Penrose St.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Margaret Steiner ~~Casey~~ Farrell

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife James W. Farrell 6. (c) Age of husband or wife if alive 72 years
7. Birth date of deceased Sept. 5th 1872
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>72</u>	<u>2</u>	<u>21</u>	hr. _____ min. _____

9. Birthplace St. Louis, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER
12. Name James Casey
13. Birthplace Ireland
(City, town, or county) (State or foreign country)
14. Maiden name Johanna Casey
15. Birthplace Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant James W. Farrell
(b) Address 3724 a Penrose St.

17. (a) Burial (b) Date thereof 11/30 /44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery
Stroot - Carroll

18. (a) Signature of funeral director _____
(b) Address 4600 Natural Bridge Ave

19. (a) NOV 28 1944 (b) J. F. Budick
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov, day 26th
year 1944 hour 8 minute 50p M.
21. I hereby certify that I attended the deceased from June 14 44
1944 to Nov. 26 1944
that I last saw er alive on Nov. 26 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Hemiplegia Duration 1 Week

Due to Central Haemorrhage non traumatic 1 Week

Due to Cerebral Sclerosis

Other conditions: High blood pressure
(Include present conditions within 3 months of death)

Major findings: 82
Of operations _____
Of autopsy _____

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?

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

23. Signatur elf. H. Vogler (M. D. or other) _____
Address 4344 W. Florissant Date signed 11/27/44

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..... *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.