

S. No. 2  
FORM-5-43  
Rev. 5-17-39  
I X36671

FILED JAN 16 1945  
Registration District No. 318

Primary Registration District No. \_\_\_\_\_

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

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:  
3225 No. Florissant Ave.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 Years.  
(Specify whether years, months or days)

In this community \_\_\_\_\_

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. 3225 No. Florissant Ave.  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country NI

3. (a) PRINT FULL NAME Mary Duffy.

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex F. 5. Color or race W.

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

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

7. Birth date of deceased June 22, 1861.  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>83</u>	<u>6</u>	<u>9</u>	hr. _____ min.

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

10. Usual occupation Housekeeper.

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Hugh Duffy.

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

14. Maiden name Marguerite Unknown.

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

16. (a) Informant Sister Jeanne.

(b) Address 3225 No. Florissant Ave.

17. (a) Burial. (b) Date thereof Jan. 3, 1945.  
(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 Rudell Blvd

19. (a) JAN 2 1945 (Date received local Registrar)  
J. F. Bredek (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 1st.  
year 1945 hour 9 minute 00 P. M.

21. I hereby certify that I attended the deceased from December 12 1944 to Jan. 1 1945  
that I last saw h. er alive on December 31 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Sem. lity  
Chronic Myocarditis

Duration 3 1/2

Due to \_\_\_\_\_

Due to 93

Other conditions None  
(Include pregnancy within 3 months of death)

Major findings: None

Of operations None

Of autopsy None

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) None

(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 work)  
Means of injury \_\_\_\_\_

23. Signature Donald K. Wolfe (M. D. or other)  
Address 2312 Salubrious St Date signed 1-2-45

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**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.**