

U.S. No. 2
FORM-5-43
Rev. 5-17-39
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3313

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED FEB 13 1945

Primary Registration District No. 3068

Registrar's No. 378

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
7320 LYNDOVER AVE.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County St. Louis

(c) City or town MAPLEWOOD
(If outside city or town limits, write "RURAL")

(d) Street No. 7320 LYNDOVER AVE. 3
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME BYRNES, ALICE MARY

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex FEM. 5. Color or race W. 6. (a) Single, widowed, married, divorced M.

6. (b) Name of husband or wife WILLIAM T. BYRNES 6. (c) Age of husband or wife if alive 73 years

7. Birth date of deceased JULY 13 1877
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEB day 6 year 1945 hour 12 minute P.M.

21. I hereby certify that I attended the deceased from Jan 31 1945 to FEB 6 1946 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

67 6 25 hr. min.

Immediate cause of death: Apoplexy

Due to Brain hemorrhage

9. Birthplace GRATTON ILL.
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWIFE

Other conditions: Myocarditis
(Include pregnancy within months of death)

Duration 8 days

11. Industry or business _____

MOTHER FATHER { 12. Name MICHAEL SCANNON

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

14. Maiden name MARGARET McHAISSEY

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

Major findings: _____

Of operations None

Of autopsy None

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant WILLIAM T. BYRNE

(b) Address 7320 LYNDOVER

17. (a) BURIAL (b) Date thereof FEB. 9 - 45.
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation SALVARY CEMETERY

18. (a) Signature of funeral director M. J. CROGHAN

(b) Address 7146 MANGUMSTEEN AVE.

19. (a) FEB 8 1945 (b) E. J. McLaughlin
(Date received locally) (Registrar's signature)

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 _____

Signature E. J. McLaughlin (M. D. or other)

Address Maplewood Mo Date signed 2-7-45

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

APR 2 1945
APR 19 1945

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. W. Wilkinson
Licensed Embalmer No. 3575
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.