

V. S. No. 2
 FORM—5-43
 Rev. 5-17-39
 I X36871

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. 4950

FILED MAR 14 1945

Registration District No. 318 Primary Registration District No. 100 Registrar's No. 1933

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:
5098 Ridge Ave.
(If not in hospital or institution, write street number or location)

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

3. (a) PRINT FULL NAME Catherine Teresa Walsh

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 Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Oct. 5 1895
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>49</u>	<u>4</u>	<u>23</u>	_____ hr. _____ min.

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

10. Usual occupation Stenographer

11. Industry or business _____

12. Name Edmund Walsh

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

14. Maiden name Ellen O' Brien

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

16. (a) Informant Josephine Walsh

(b) Address 5098 Ridge Ave.

17. (a) Burial (b) Date thereof 3-1-45
(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 28 1945 (b) J. F. Bruck
(Date received by local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 17

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 5098 Ridge Ave.
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 27, year 1945 hour 6 minute 50 A. M.

21. I hereby certify that I attended the deceased from Sept 1 1944 to Feb 27 1945
 that I last saw h. alive on Feb 23 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death Sepsis

Due to Infected Red sores Duration 1 mo

Due to old Paralysis Duration 10 years +

Other conditions 82
(Include pregnancy within 3 months of death)

Major findings: Of operations No

Of autopsy No

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) No

(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)

(c) Means of injury _____

23. Signature Wm J. Langand (M. D. or other) D
 Address 5803 Plymouth Date signed Feb 17/45

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.