

S. No. 2
OM-5-43
ev. 5-17-39
I X36871

FILED MAR 16 1945

Registration District No. **318** Primary Registration District No. **1000**

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:
2136 Adelaide 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 Mary Lahey

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 Sept. 22 1871
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>73</u>	<u>5</u>	<u>13</u>	hr. _____ min. _____

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

10. Usual occupation At Home

11. Industry or business _____

12. Name Pabbick Lahey

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

14. Maiden name Winifred Connors

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

16. (a) Informant Mrs. J. A. Mulqueen

(b) Address 2136 Adelaide Ave.

17. (a) Burial (b) Date thereof 3-8-45
(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 Randall Blvd

19. (a) MAR 7 1945 J. F. Budeck
(Date received by Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: **000**

(a) State Mo. (b) County 112

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

(d) Street No. 2136 Adelaide Ave.
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 5, year 1945 hour 2:45 minute P. M.

21. I hereby certify that I attended the deceased from 2/24/45 1945 to 3/5/45 1945
that I last saw her alive on 3/5/45 1945
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Cerebral Hemorrhage

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) IV6

(b) Date of occurrence No

(c) Where did injury occur? No (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? No (Specify type of place) (e) Means of injury _____

23. Signature Paul Rematorff (M. D. or other) _____
Address 3914 W. Pleasant Date signed 3/6/45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

For Embalmer
3919 W 5th
1-3

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. 3868

P. O. Address 3840 Lindell

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.