

11120

State File No. _____

FILED MAY 12 1945

318

Primary Registration District No. _____

1003

Registrar's No. 3745

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
4045 Utah 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 Mo (b) County 000

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

(d) Street No. 4045 Utah Pl
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Catherine Cronin

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife John Cronin Sr

6. (c) Age of husband or wife if alive 80 years

7. Birth date of deceased Unknown
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 25
 year 1945 hour 1.15 AM minute _____ M.

21. I hereby certify that I attended the deceased from July 29 1945
 1943 to April 25 1945
 that I last saw him alive on 4/24 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death Diabetes Mellitus

Duration 15 yrs

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 6/1

8. AGE abt 83
 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation Housework

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings: _____

Of operations _____

Of autopsy _____

MOTHER FATHER {

11. Industry or business At Home

12. Name Micheal Mulderig

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

14. Maiden name Ellen Gillespie

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

16. (a) Informant Micheal F. Cronin

(b) Address 4045 Utah Pl

17. (a) Burial (b) Date thereof 4 28 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director KRIEGSHAUSER

(b) Address 4228 So. Kingshighway

19. (a) ADD 2 - 2 (b) J. F. Bredack
(Date received local registrar) (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 0

23. Signature William H. Broderick (M. D. or other) MD

Address 1325 Midway Date signed 4/26/45

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

60
17
9

Dr. Broeder
12 th Sidney St

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..... *Clavin D. McDermond*

Licensed Embalmer No. 3024

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.