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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 3 1945 818

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 11077

Registration District No. ..... Primary Registration District No. 1003 Registrar's No. 3696

1. PLACE OF DEATH:

(a) County .....

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

(c) Name of hospital or institution: DePaul Hosp 0 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1/2 Mo (Specify whether

In this community ..... years, months or days)

2. USUAL RESIDENCE OF DECEASED: 000 17 95

(a) State Mo. (b) County .....

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

(d) Street No. 5643 Cabanne Ave (If rural, give location)

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

If yes, name country .....

3. (a) PRINT FULL NAME William Edward Quinn Sr.

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male 0

5. Color or race White

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

6. (b) Name of husband or wife May G.

6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased April 28th. 1886 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
58	11	26	hr. min.

9. Birthplace St. Louis (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation Police Officer

11. Industry or business St. Louis Police Dept

FATHER
12. Name William E Quinn
13. Birthplace ..... (City, town, or county) Mo. 0 (State or foreign country)

MOTHER
14. Maiden name Mary Jones
15. Birthplace ..... (City, town, or county) Ireland 4 (State or foreign country)

16. (a) Informant John J Quinn

(b) Address 5643 Cabanne Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/27/45 (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemt.

18. (a) Signature of funeral director Harrigan & Sheanan Und Co

(b) Address 4415 Washington Blvd.

19. (a) APR 26 1945 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 24th. year 1945 hour 8:00 PM. minute ..... M.

21. I hereby certify that I attended the deceased from SEPT. 21, 1944, to APR. 24, 1945 that I last saw him alive on APR. 24, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
ACUTE MYELOGENOUS LEUKEMIA	about 1 YR
Due to Unknown	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
~~Of autopsy~~ Bone marrow puncture	

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) .....

(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? ..... (Specify type of place)

While at work? ..... (e) Means of injury 0

23. Signature James H. Cummings M. D. (M. D. or other)

Address 1444 N. Euclid Av. Date signed 4/25/45

(Licensed Embalmer's Statement on Reverse Side)

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 Albert G. Kappe

Licensed Embalmer No. 2971

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.