. S. No. 2
00M—2-43
ev. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 6 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 29169

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8285

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:
Josephine Hosp 0
(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 17 18
(If outside city or town limits, write "RURAL")

(d) Street No. 4440 Gibson Ave 9
(If rural, give location) 1

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

If yes, name country

3. (a) PRINT FULL NAME Matt Lavey

3. (b) If veteran, name war No

3. (c) Social Security No.

4. Sex Male 0

5. Color or race White

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

6. (b) Name of husband or wife Julia

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

7. Birth date of deceased July (Month) 24 (Day) 1874 (Year)

8. AGE: Years 71 Months 1 Days 28 If less than one day hr. min.

9. Birthplace Ireland (City, town, or county) 4 (State or foreign country)

10. Usual occupation Motorman

11. Industry or business Public Service Co

FATHER
12. Name Unknown
13. Birthplace Ireland (City, town, or county) 4 (State or foreign country)

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

16. (a) Informant Mrs Catherine Steger

(b) Address 4440 Gibson Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 25 45 (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Kriegshauser

(b) Address 4228 So. Kingshighway

19. (a) SEP 24 1945 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 22 year 1945 hour 1.25 AM minute M.

21. I hereby certify that I attended the deceased from Aug 6, 1945 to Sept 22, 1945; that I last saw him alive on Sept 21, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Idiopathic Aplastic Anemia

Due to

Due to 73

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy No other findings

Duration

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

23. Signature [signature] (M. D. or other) M.D.

Address 1446 S. Grand Date signed 9-24-45

(Licensed Embalmer's Statement on Reverse Side)

Dr De Pew
So Grand

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 Richard W. Storesand

Licensed Embalmer No. 4007

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.