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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1023

FILED JAN 21 1946

Registration District No. _____ Primary Registration District No. 1003 Registrar's No. 90

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:
St. Johns Hospital
(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 96
(c) City or town Kirkwood. 4
(If outside city or town limits, write "RURAL")
(d) Street No. St. Agnes Home. NR3
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No) 1
If yes, name country _____

3. (a) PRINT FULL NAME Margaret A. Troy.

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F. 1 | 5. Color or race W. | 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 March (Month) 2 (Day) 1874 (Year)

8. AGE: Years	Months	Days	If less than one day
71	10	1	hr. _____ min.

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

10. Usual occupation Nil

11. Industry or business _____

FATHER
12. Name William Troy
13. Birthplace Dont Know (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name Dont Know
15. Birthplace Dont Know (City, town, or county) 9 (State or foreign country)

16. (a) Informant Edward A. Warren 1
(b) Address # 30 Summit Place.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-7-46 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery.

18. (a) Signature of funeral director A. J. Donnelly
(b) Address 3840 Lindell

19. (a) JAN 4 1946 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 3.
year 1946 hour 7 minute 45 P.M.

21. I hereby certify that I attended the deceased from 5/26, 1945, to Jan 3, 1946; that I last saw her alive on Jan 3, 1946; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Rt. Lobar Pneumonia	3 days
Due to Carcinoma of Esophagus with obstruction (complete)	8 mos. 7 mos.
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations _____
Of autopsy _____

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 John [illegible] M.D. (M.D. or other)
Address 6716 Big Bend Rd. Date signed 1/4/46
Kirkwood, Mo

(Licensed Embalmer's Statement on Reverse Side)

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

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 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.