

S. No. 2
M-5-43
v. 5-17-39
I X36871

FILED MAR 20 1946
318

STANDARD CERTIFICATE OF DEATH

State File No. **11035**
Registrar's No. **2294**

Registration District No. _____ Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County **St. Louis**

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

(c) Name of hospital or institution:
Firmin Desloge 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 **Missouri** (b) County _____

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

(d) Street No. **3830 Park Ave.**
(If rural, give location)

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

3. (a) PRINT FULL NAME **Isabelle C. Daly**

3. (b) If veteran, name war **Nil** **3. (c) Social Security No.** **None**

4. Sex **Female** **5. Color or race** **White** **6. (a) Single, widowed, married, divorced** **Widow**

6. (b) Name of husband or wife _____ **6. (c) Age of husband or wife if alive** _____ years

7. Birth date of deceased **September 19 1894**
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **6**
year **1946** hour **9** minute **50 A.M.**

21. I hereby certify that I attended the deceased from **2/7**, 19**46** to **3/6**, 19**46**
that I last saw h. **u** alive on **3/6**, 19**46**
and that death occurred on the date and hour stated above.

Immediate cause of death: **Cardiac failure**

Due to: **Rheumatic Ht. Disease** **39 yrs.**

8. AGE:	Years	Months	Days	If less than one day
	51	5	17	hr. _____ min. _____

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

Major findings: **None**

Of operations _____

Of autopsy **None**

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

10. Usual occupation **Housewife**

PHYSICIAN

Underline the cause to which death should be charged statistically.

11. Industry or business _____

12. Name **John McDonnell**

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

14. Maiden name **Julia Chenot**

15. Birthplace **St. Louis Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Jane Foley**

(b) Address **3830 Park Ave.**

17. (a) Burial **(b) Date thereof** **3-9-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

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? _____

18. (a) Signature of funeral director **Albert H. Hoppe**

(b) Address **4700 Washington Blvd.**

19. (a) MAR 8 1946 **(b) [Signature]**
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)

23. Signature **Richard S. H. Fleberty** **(M. D. or other)** **M.D.**
Firmin Desloge **Date signed** **3/12/46**

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

9947

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.....

Henry M. Brammer

Licensed Embalmer No.....

4200

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.