

FILED NOV 25 1946
 Registration District No. **318**

Primary Registration District No. _____

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

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: **City Sanitarium**
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **5yrs 1mo 13ds.**
(Specify whether years, months or days)
 In this community **81years**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **THOMAS QUIRK**
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Male** 5. Color or race **white** 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 **July 13 1865**
(Month) (Day) (Year)

8. AGE: Years **81** Months **3** Days **29** If less than one day
 hr. _____ min. _____

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

10. Usual occupation **nil**

11. Industry or business _____

MOTHER FATHER
 12. Name **not known**
 13. Birthplace **not known** (City, town, or county) (State or foreign country)
 14. Maiden name **not known**
 15. Birthplace **not known** (City, town, or county) (State or foreign country)

16. (a) Informant **Thelma A Singler**
 (b) Address **5400 Arsenal St**

17. (a) **BURIAL** (b) Date thereof **11 15 46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **CALVARY CEMETERY**

18. (a) Signature of funeral director **KRIEGSHAUSER UND CO**
 (b) Address **4222 S. KINGSHIGHWAY**

19. (a) **NOV 13 1946** (b) **J. F. Bradeck**
(Date received local registrar) (Registrar's signature)

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. **5400 Arsenal St**
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **12th**
 year **1946** hour **10:20** minute **P.** M. _____

21. I hereby certify that I attended the deceased from **Sep't 29 1941** to **Nov., 12, 1946**
 that I last saw him alive on **Nov., 12, 1946**
 and that death occurred on the date and hour stated above.

Immediate cause of death:
Bilateral Broncho-pneumonia 5 days.
Generalized Arteriosclerosis 1941x

Due to _____

Due to _____

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

Major findings:
 Of operations _____

Of autopsy **no**

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) (e) Means of injury _____

23. Signature **J. Hopwater** (M. D. or other) **M.D.**

Address **5400 Arsenal** Date signed **11/13/46**

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. Storsand*

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.