

No. 2
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DEPARTMENT OF HEALTH
BUREAU OF THE CENSUS
FILED MAR 14 1947
317
Registration District No. 317

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
Primary Registration District No. 26076

State File No. 7369
Registrar's No. 167

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

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Koch
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Koch 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 817 days
years, months or days

3. (c) PRINT FULL NAME John Francis Devine
3. (b) If veteran, name war no 3. (c) Social Security No. _____

4. Sex M 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 Jan 29 1879
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
68 2 13 _____ hr. _____ min.

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

10. Usual occupation none

11. Industry or business _____

MOTHER FATHER
12. Name Patrick Devine
13. Birthplace _____ Ireland
(City, town, or county) (State or foreign country)
14. Maiden name Ann McNamee
15. Birthplace _____ Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant Hospital Record
(b) Address Koch Hospital
17. (a) BURIAL (b) Date thereof 3-15-47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation CALVARY

18. (c) Signature of funeral director SOUTHERN FUNERAL HOME
(b) Address 6322 S. GRAND BLVD.
3-14-47 (Date received local registrar)
(c) Ruth J. Allen MD (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County _____
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 3525 Chippewa 9
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 12
year 1947 hour 12 minute 20 A. M.

21. I hereby certify that I attended the deceased from May 1,
1946, to March 2, 1947;
that I last saw him alive on March 1, 1947;
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Cor
pulmonary
Due to Chronic Pulmonary tuber-
culosis, far advanced
Due to _____
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Other conditions syphilis, late late
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy Corpulmonary
pulmonary tuberculosis

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? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature Charles Silverberg (M. D. or other) M. D.
Address Koch Hospital, Koch Date signed 3/12/47

Duration
2 years

Duration
4 years

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

John D. Dumbley

Licensed Embalmer No.

3657

P. O. Address

St Louis Mo

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.