

No. 2
12-45
17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 31 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

10947

State File No. _____

Registration District No. **318**

Primary Registration District No. _____

Registrar's No. **2858**

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 **0**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 Years
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. Park Plaza Hotel
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Annie Tracy Harrold

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

4. Sex F. / 5. Color or race W.
6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased Sept. 29. 1858
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
88 5 18 hr. min. **0**

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

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER

12. Name Michael Tracy

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

14. Maiden name Margaret Page

15. Birthplace Ireland **11**
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Louis A. Reuter

(b) Address # 2 Kingsbury Blvd.

17. (a) Burial (b) Date thereof 3-19-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Arthur J. Donnelly

(b) Address 3840 Euclid Blvd.

19. (a) MAR 18 1947 (b) J. F. Brennan
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 17th
year 1947 hour 4 minute 20 A.M.

21. I hereby certify that I attended the deceased from Feb. 45 to 3-17, 1947
that I last saw her alive on 3-16, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Cecum
Duration 1 year

Due to _____

Due to _____

Other conditions none
(Include pregnancy within 3 months of death)

Major findings: Of operations none

Of autopsy as above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(c) Accident, suicide, or homicide (specify) None

(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 _____

Signature John J. Hammond (M. D. or other) M.D.

Address 6314 N. Grand Date signed 3/17/47

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 W.H. Van Mater
Licensed Embalmer No. 2825
P. O. Address 4340 Lafayette

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.