

No. 2  
12-45  
17-39  
X47070

FILED MAR 24 1947 318

Primary Registration District No. 1003

Registrar's No. 2546

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:  
Little Sisters of the Poor 5  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1-year  
(Specify whether)

In this community 21 yrs.  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County \_\_\_\_\_

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

(d) Street No. 3225 N. Florissant Ave.  
(If rural, give location)

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

3. (a) PRINT FULL NAME Alice Hughes

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 9th.,  
year 1947 hour 6 minute 30 P. M.

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Unk. Unk. 1958  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased March 1 1947 March 9 1947  
or March 8 1947  
that I last saw her alive on \_\_\_\_\_ and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

89 Unk. Unk. \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Chronic Myocarditis  
Senility

Duration ???

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

10. Usual occupation Dressmaker

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

MOTHER FATHER

11. Industry or business \_\_\_\_\_

12. Name Patrick Hughes 4

13. Birthplace Ireland 1  
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Callan 4

15. Birthplace Ireland 1  
(City, town, or county) (State or foreign country)

Major findings:  
Of operations None

Of autopsy None

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

16. (a) Informant Sister Jeane

(b) Address 3225 N. Florissant Ave.

17. (a) Burial (b) Date thereof 3-11-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Walter J. Kennolly

(b) Address 3840 Lindell Blvd.

19. (a) MAR 11 1947  
(Date received local registrar)

J. F. Breda  
(Embalmer's signature)

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 \_\_\_\_\_ (Specify type of place) \_\_\_\_\_  
Cause of injury \_\_\_\_\_

23. Signature Walter J. Kennolly (M. D. or other) \_\_\_\_\_  
Address 1302 S. Delmar St. Date signed 3-10-47

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 *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.**