

No. 2
-12-45
-17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11104

State File No. _____

FILED MAR 31 1947
318

Registration District No. _____

Primary Registration District No. 1003

Registrar's No. 2856

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 Poor 3225 N. Florissant
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 Years 4 Mo.
(Specify whether
In this community _____
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 No. Florissant Ave.
(If rural, give location)

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

3. (a) PRINT FULL NAME Mary Kirk

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F. / race W.

5. Color or _____

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: March 20, 1867
(Month) (Day) (Year)

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

79	11	26	hr. _____ min.
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9. Birthplace: Lafayette, Indiana
(City, town, or county) (State or foreign country)

10. Usual occupation Housekeeper

11. Industry or business _____

12. Name William Kirk

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

14. Maiden name Maria Kelly

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

16. (a) Informant Sister Jeanne

(b) Address 3225 No. Florissant Ave.

17. (a) Burial (b) Date thereof 3-18-47
(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 Knight Blvd

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. Day 16th
year 1947 hour 8 minute 30 P. M.

21. I hereby certify that I attended the deceased from June 1 1946 to March 16 1947
that I last saw h. pr alive on March 16 1947
and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Myocarditis
Duration 10 mo

Due to _____

Due to _____

Other conditions Pernicious Anemia ??
(Include pregnancy within 3 months of death)

Major findings: None

Of operations _____

Of autopsy None

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) 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 _____

23. Signature Edward A. [unclear] (M. D. or other) _____

Address 3302 Calvary St Date signed 3-17-47

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

MOTHER FATHER

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 Matre

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.