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State File No.

FILED APR 14 1947 #69568

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Registrar's No. 2592

Registration District No. 318 Primary Registration District No.

1. PLACE OF DEATH:

(a) County.....

(b) City or town St. Louis, Missouri.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Louis City Hospital - Max C. Starkloff
(If not in hospital or institution, write street number or location) Memorial

(d) Length of stay: In hospital or institution.....
(Specify whether

In this community.....
years, months or days)

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. 5885 Romaine Pl
(If rural, give location)

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

3. (a) PRINT FULL NAME CECELIA WALSH

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 3rd
year 1947 hour 1:00 minute A M.

4. Sex Female 5. Color or race Wh

6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased May 5, 1872
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 3/22/47, 19....., to April 3rd, 19 47
that I last saw h. er alive on April 3rd, 19 47
and that death occurred on the date and hour stated above.

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

<input checked="" type="checkbox"/>	74	10	28 hr. min.
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Immediate cause of death Cerebral Insufficiency Duration Weeks

9. Birthplace Louisiana Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

Due to.....

Due to Arteriosclerotic Heart Disease 93 years

Other conditions (include pregnancy within 3 months of death).....

MOTHER FATHER

11. Industry or business.....

12. Name John Lonergan

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

14. Maiden name Mink

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

Major findings: Of operations.....

Of autopsy Denied

PHYSICIAN.....

Underline the cause to which death should be charged statistically.

16. (a) Informant John M. Walsh

(b) Address 5885 Romaine Pl

17. (a) Burial (b) Date thereof 4-5-47
(Burial, cremation or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lafayette

18. (a) Signature of funeral director Chas. F. Starn

(b) Address 1225 Union

19. (a) APR 4 1947 (b) J. F. Brueck
(Date received local registrar) (Registrar's signature)

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)

(c) Means of injury.....

23. Signature Hubert Smith (M. D.) 4/3/47

Address 1515 Lafayette Date signed.....

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

Henry M. Drimmer

Licensed Embalmer No.

4200

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.