

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

FILED APR 25 1947
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Registrar's No. **3968**

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution: Alexian Brothers Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

3. (a) PRINT FULL NAME James Hayes

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

4. Sex Male 5. Color or race White

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 April 3 1873
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>74</u>	<u>0</u>	<u>11</u>	hr. _____ min. _____

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

10. Usual occupation Hospital Attendant

11. Industry or business _____

MOTHER FATHER

12. Name Don't Know

13. Birthplace Don't Know Ireland
(City, town, or county) (State or foreign country)

14. Maiden name Don't Know

15. Birthplace Don't Know Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant Hospital Records

(b) Address 3933 S. Broadway

17. (a) Burial (b) Date thereof 3-17-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Weick Bro. Und. Co.

(b) Address 2201 S. Grand Bl.

19. (a) APR 16 1947 (Date received local Registrar) J. F. Predeck (Registrar's signature)

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. 3933 S. Broadway
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 14
year 1947 hour 4 minute 45 P. M.

21. I hereby certify that I attended the deceased from March 1947 to April 14 1947
that I last saw him alive on April 14 1947
and that death occurred on the date and hour stated above.

Immediate cause of death: Cardiac failure

Due to Valvular Heart Disease
Myocardial Insufficiency

Due to _____

Other conditions: Atherosclerosis
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

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 B. J. Mc Ginn (M. D. or other) 0

Address 3608 S. Grand Date signed 4/15/47

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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.....

..... **James R. Dunn**, Registered Apprentice No. **403**
working under my personal supervision.

Signed.....

Wm. H. Stewart

Licensed Embalmer No. **3722**

P. O. Address **2201 S. Grand Bl.**

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.