

3. No. 2  
-12-45  
5-17-39  
I X47070

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

18900

FILED MAY 22 1947  
318

State File No. \_\_\_\_\_

Registration District No. \_\_\_\_\_

Primary Registration District No. 1003

Registrar's No. 4897

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 POP. S. GRAND BLV  
(If not in hospital or institution, write street number or location)

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

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County 000  
17

(c) City or town ST. LOUIS  
(If outside city or town limits, write "RURAL")

(d) Street No. 3400 S. GRAND BLV.  
16 (If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MARY HALLORAN

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

4. Sex FEMALE 5. Color or race W 6. (a) Single, widowed, married, divorced WIDOW

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

7. Birth date of deceased 9 1864  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 13 year 1947 hour 4 minute 30 P M.

21. I hereby certify that I attended the deceased from May 11 to May 13 that I last saw him/her alive on May 13 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Haemorrhage Duration 4 Day

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

about 82 hr. min.

Due to Apertures 1 yr

Due to Arterio Sclerosis 2 yr

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

10. Usual occupation NIL

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 82

Of autopsy \_\_\_\_\_

MOTHER FATHER

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

12. Name UNKNOWN LEE 9

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

14. Maiden name UNKNOWN UNKNOWN

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

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. J. Quinn

(b) Address 406 S. Cornwell

17. (a) BURIAL (b) Date thereof MAY 16-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director E. J. Behrman

(b) Address 3125 Lafayette Av

19. (a) MAY 15 1947 (b) J. Z. Proctor  
(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)

(a) Means of injury Car

23. Signature J. Z. Proctor (M. D. or other) J. Z. Proctor

Address 607 W. Grant Date signed 5/14/47

(Licensed Embalmer's Statement on Reverse Side)

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

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**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.....

*Just B. Vollmer*

Licensed Embalmer No. *4014*

P. O. Address

*3125 Lafayette Ave*

**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.**