

S. No. 2  
M-1/47  
v. 5-17-39

FILED 73 AUG 8 1947  
Registration District No. 1003

Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County.....  
 (b) City or town..... **St. Louis, Mo.**  
(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)  
 (d) Length of stay: In hospital or institution..... **2 weeks**  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... **Missouri** (b) County..... **St. Louis**  
 (c) City or town..... **St. Louis**  
(If outside city or town limits, write "RURAL")  
 (d) Street No..... **4307 Farlin Ave**  
**Memorial** (If rural, give location)  
 (e) Citizen of foreign country?..... **no** (Yes or No)  
 If yes, name country.....

3. (a) PRINT FULL NAME..... **MATTHEW TIERNEY**  
 3. (b) If veteran, name war..... **none**  
 3. (c) Social Security No..... **unknown**  
 4. Sex..... **male** 5. Color or race..... **white**  
 6. (a) Single, widowed, married, divorced..... **married**  
 6. (b) Name of husband or wife..... **Louise**  
 6. (c) Age of husband or wife if alive..... **57** years  
 7. Birth date of deceased..... **Sept 26 1884**  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... **July** day..... **29th**  
 year..... **1947** hour..... **12:40** minute..... **P** M.  
 21. I hereby certify that I attended the deceased..... **7/21/47**  
 from..... **19** to..... **July 29th** 19 **47**  
 that I last saw him alive on..... **July 29th** 19 **47**  
 and that death occurred on the date and hour stated above.

8. AGE: Years Months Day If less than one day  
**62 10 29** hr. min.

Inmediate cause of death..... **Pulmonary Tuberculosis**  
 Due to.....  
 Due to.....  
 Other conditions..... **1 1/2**  
(Include pregnancy within 3 months of death)

9. Birthplace..... **MD**  
(City, town, or county) (State or foreign country)  
 10. Usual occupation..... **Maintenance man**  
 11. Industry or business..... **Costers Carbonates**  
 12. Name..... **JOHN TIERNEY**  
 13. Birthplace..... **Ireland**  
(City, town, or county) (State or foreign country)  
 14. Maiden name..... **CATHERINE GAMB**  
 15. Birthplace..... **Ireland**  
(City, town, or county) (State or foreign country)

Major findings:  
 Of operations.....  
 Of autopsies.....  
 PHYSICIAN  
 Underline the cause of which death should be charged statistically.

16. (a) Informant..... **Louise Tierney**  
 (b) Address..... **4307 FARLIN**  
 17. (a) Burial, cremation, or removal..... **Burial**  
 (b) Date thereof..... **8 1 47**  
(Month) (Day) (Year)  
 (c) Place: burial or cremation..... **Galway**  
 18. (a) Signature of funeral director..... **Joe J. Quinn**  
 (b) Address..... **1389 Union Blvd**  
 19. (a) **JUL 31 1947** (Date received local registrar)  
 (b) **J. F. Bredner** (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?.....  
(Specify type of place)  
 While at work?.....  
 23. Signature..... **George Smith**  
**1515 Lafayette** **7/29/47**  
 Address..... Date signed.....

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..... *Ronald O Yalake*.....

Licensed Embalmer No. *3917*.....

P. O. Address..... *St Louis*.....

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.

*Aug*  
*7/3/47*

Registration District No. *318*

Primary Registration District No. *1003*

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:  
  
(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)

3. (a) PRINT FULL NAME

*Matthew Tierney*

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

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

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

7. Birth date of deceased *Sept 26 1903*  
(Month) (Day) (Year)

8. AGE: Years Months Days (If less than one day) hr. min.  
*62 10 26*

9. Birthplace *St. Louis, Mo*  
(City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) (Date received local registrar) (b) *J. F. Breneck* (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....  
(c) City or town..... (If outside city or town limits, write "RURAL")  
(d) Street No..... (If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... Year *1947* hour..... minute..... M. *29*

21. I hereby certify that I attended the deceased from..... to....., 19.....; that I last saw him alive on....., 19.....; and that death occurred on the date and hour stated above. Immediate cause of death.....

Duration

Due to.....  
Due to.....

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

Major findings: Of operations.....

Of autopsy.....

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).....

(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..... (M. D. or other)

Address..... Date signed.....

**SUPPLEMENTARY**

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

AUG 14 1947

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