No. 2
1/47
27-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED SEP 2

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 225589

Registration District No. hist. 173 318 Primary Registration District No. 1003 Registrar's No. 2080

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 #1
(If not in hospital or institution, write street address or location)

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

In this community

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. Father Dempsey's Home
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Francis Tierney

3. (b) If veteran, name war Unknown

3. (c) Social Security No. Unknown

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 About 1864? (Month) (Day) (Year)

8. AGE: Years abt - 83? Months ? Days If less than one day hr. min.

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

10. Usual occupation O.A.P.

11. Industry or business

FATHER
12. Name Michael Tierney
13. Birthplace Unknown (City, town, or county) Ireland (State or foreign country)

MOTHER
14. Maiden name Mary Unknown
15. Birthplace Unknown (City, town, or county) Ireland (State or foreign country)

16. (a) Informant St. Louis City Hospital records
(b) Address 1515 Lafayette Avenue.,

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/22/47 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.,

19. (a) Date received by registrar AUG 22 1947 (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 21st year 1947 hour 12:55 minute P M.

21. I hereby certify that I attended the deceased from 7-17-47, 19..., to 8-21-47, 19...; that I last saw him alive on 8-21-47, 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Benign Prostatic Hypertrophy with Uremia	
Due to:	
Due to:	
Other conditions. (Include pregnancy within 3 months of death)	

Major findings:
Of operations:
Of autopsy:

PHYSICIAN — Underline the cause of 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? (Specify type of place)
While at work? Means of injury
Signature (M. D., or other)
Address 1515 Lafayette Date signed

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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 No Embalm

Licensed Embalmer No.....

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.