

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... 2919 CASS
 (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
 (c) City or town... ST. LOUIS
 (If outside city or town limits, write "RURAL")
 (d) Street No... 2908 A CASS
 (If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

3. (a) PRINT FULL NAME THOMAS QUINNEY
 3. (b) If veteran, name war.....
 3. (c) Social Security No.

4. Sex M 2. Color or race W
 6. (a) Single, widowed, married, divorced WIDOWED
 6. (b) Name of husband or wife.....
 6. (c) Age of husband or wife if alive..... years
 7. Birth date of deceased... Nov 8 1895
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>52</u>	<u>6</u>	<u>28</u> hr. min.

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

10. Usual occupation... LABOR.

11. Industry or business.....

12. Name... SAM. QUINNEY

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

14. Maiden name... MARRAH FELTS

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

16. (a) Informant... LEANA KENNEDY

(b) Address... 2919 CASS

17. (a) BURIAL (b) Date thereof... 6/10/48
 (Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director... F. A. GREEN

(b) Address... 4214 DELTA

19. (a) JUN 8 1948 (b) G. F. BRUCE
 (Date received local registrar's certificate) (Registrar's signature)

20. DATE OF DEATH: Month JUNE day 6
 year 1948 hour 9 minute 45

21. I hereby certify that I attended the deceased from May 22, 48 to June 6, 48
 that I last saw him on June 6 and that death occurred on the date and hour stated above.

Immediate cause of death... Mitral Insufficiency
 Due to.....

Due to... Chr. Nephritis

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

Major findings: Of operations... 1/2!

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)

23. Signature... Art Graddock M. D. or other.....

Address... 1005 N. Highway Date signed... 6-8-48

Duration

PHYSICIAN

Underline the cause of which death should be charged statistically.

MOTHER FATHER

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 *F. A. Seaman*

Licensed Embalmer No. 2963

P. O. Address 4214 Palmer

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.