

300
-10-47
-17-39
1906

FEDERAL SECURITY AGENCY # 88314

MISSOURI DIVISION OF HEALTH

28320

National Office of Vital Statistics
FILED AUG 23 1948

STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **7114**

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis, Missouri
(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 Memorial
(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 _____

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 1401 S Ewing
18
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Florence Whelan

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 12th
year 1948 hour 3 minute 50 P. M.

21. I hereby certify that I attended the deceased from 7-29-48
_____ 19____, to 8-12-48 19____;
that I last saw h er alive on 8-12-48 19____;
and that death occurred on the date and hour stated above.

4. Sex FEM 5. Color on race Wh.

6. (a) Single, widowed, married, divorced 7

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: JUL 27 1895
(Month) (Day) (Year)

Immediate cause of death: 24REMIA

Duration _____

8. AGE: Years 53 Months 0 Days 16
If less than one day hr. _____ min. _____

Due to arteriosclerotic nephrosclerosis

Due to _____

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

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

10. Usual occupation: Housewife

Major findings: 1/21

Industry or business: Peter Killmade

Of operations: _____

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

Of autopsy: _____

14. Maiden name: Rose Fahys

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

22. If death was due to external causes, fill in the following:

(a) Informant: Margaret M. Jones

(a) Accident, suicide, or homicide (specify) _____

(b) Address: 1437 Hickory Lane

(b) Date of occurrence _____

17. (a) Burial (b) Date thereof: 8-16-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Where did injury occur? _____
(City or town) (County) (State)

(c) Place: burial or cremation: Calvary

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

18. (e) Signature of funeral director: E. J. Schuyler

While at work? _____ (Specify type of place)
(e) Means of injury: !

(b) Address: 3125 Lafayette Ave

23. Signature: Bliss L. Bryan (M. D. or other) _____
Address: 1515 Lafayette Avenue Date signed: 8-13-48

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

MOTHER EATHERS

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.....

Joe B. Holmes

Licensed Embalmer No.....

4014

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.

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

4. Sex F 5. Color or race N 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife John 6. (c) Age of husband or wife if alive 53 years

7. Birth date of deceased July 27 (Month) (Day) (Year)

8. AGE: Years 53 Months _____ Days _____ (Less than one day) hr. _____ min. _____

9. Birthplace _____ (City, town, or county) (State or foreign country) No

10. Usual occupation Domestic

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) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) (Place: burial or cremation)

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) _____ (b) J. F. Brodeur (Date received local registrar) (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 Aug year 1948 hour _____ minute _____ M.

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 _____

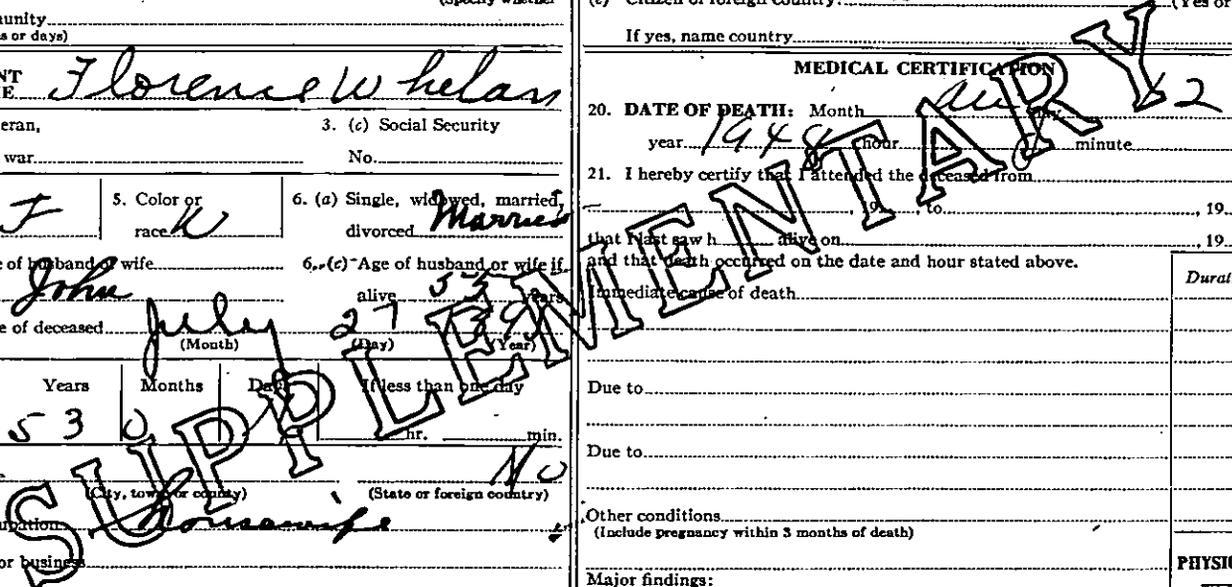
Due to _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____

Duration _____
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 _____



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

AUG 25 1948

28320

2844-29
1-8-77

THE STATE BOARD OF HEALTH OF MISSOURI
BUREAU OF VITAL STATISTICS

State of _____ }
County of _____ } ss.

State File No. _____

AFFIDAVIT FOR CORRECTION OF A RECORD

Local Registrar's No. 7114

On this _____ day of _____, 19____, before me appears _____

_____ , who, upon _____ oath, states that the original record of birth
for Florence Whelan died 8-12-48, 19____, in the State of death
Missouri, and which was filed at _____ on _____, 19____, should be corrected as follows:

Item No. 6b should read Daniel James Whelan

Instead of _____

Item No. 6c should read 53

Instead of _____

Item No. _____ should read _____

Instead of _____

Item No. _____ should read _____

Instead of _____

Item No. _____ should read _____

Instead of _____

Item No. _____ should read _____

Instead of _____

Item No. _____ should read _____

Instead of _____

Item No. _____ should read _____

Instead of _____

The above is true to the best of my knowledge, information and belief.

(SEAL) Affiant Margaret Jones Inf Relationship _____

1437 Hickory Present Address _____

Subscribed and sworn to before me this 20 day of Sept., 1948

My Commission expires 3-4-49. Ellen Paltow Notary Public.

Affidavits containing erasures will not be accepted; draw one line through error and write above it.

28320