

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County **St. Louis, Mo.**
(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 **12 days**
In this community **19 years**
years, months or days (Specify whether)

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. **3225 Montgomery St., Memorial**
(If rural, give location)
(e) Citizen of foreign country? **unknown** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **Thomas Farrelly**

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

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 **February 2nd**
(Month) (Day) (Year)

8. AGE: Years **abt 79** Months **-** Days **-** If less than one day hr. min.

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

10. Usual occupation **OAA**

11. Industry or business _____

12. Name **Thomas Farrelly**

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

14. Maiden name **Mary Unknown**

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

16. (a) Informant **MARGARET - KELLY**

(b) Address **2331 MULLAIVPHY**

17. (a) **BURIAL** (b) Date thereof **9-23-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **CALVARY**

18. (a) Signature of funeral director **Brayden Kelly**

(b) Address **4386 Lyndell**

19. (a) **SEP 22 1948** (b) **J. F. Brock**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **19th**
year **1948** hour **10** minute **20** P. M.

21. I hereby certify that I attended the deceased from **9/7/48**
to **Sept. 19th**, 19 **48**
that I last saw h **1m** alive on **Sept. 19th**, 19 **48**
and that death occurred on the date and hour stated above.

Immediate cause of death **Ca. of Bladder & Urinary**

Due to _____
Due to **52**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____
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? **St. Perinington** (Specify type of place) (e) Means of injury _____
23. Signature **1515 Lafayette** **9/20/48**
Address Date signed

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

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 *Ralph W. Henson*.....

Licensed Embalmer No. *3791*.....

P. O. Address *St. Louis, MO*.....

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.