

21815

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. **5265**

FILED JUN 27 1949

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4065 Utah St.		d. STREET ADDRESS (If rural, give location) 4065 Utah St.	

3. NAME OF DECEASED (Type or Print) a. (First) James b. (Middle) J. c. (Last) Walsh			4. DATE OF DEATH (Month) (Day) (Year) June 15 1949		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Sept. 24, 1889		9. AGE (In years last birthday) 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME Thomas Walsh	13b. MOTHER'S MAIDEN NAME Mary Ann Doyle	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Thomas B. Hayes 4065 Utah St.	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion.		INTERVAL BETWEEN ONSET AND DEATH 4 hrs
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterio-sclerosis.		
	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 97
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4th floor

22. I hereby certify that I attended the deceased from **June 15, 1949** to **June 15, 1949**, that I last saw the deceased alive on **June 15, 1949**, and that death occurred at **10:55 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Edmund R. Sheridan M.D.	23b. ADDRESS 2602 So. Grand Blvd.	23c. DATE SIGNED 6-17-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 6-18-1949	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Missouri
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DATE REC'D BY LOCAL REG. JUN 17 1949	REGISTRAR'S SIGNATURE J. B. Casate	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Weick Bro. Und. Co. 2201 S. Grand Bl.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

No. 300
10.48

M. Williams
Blair & Son
JUL 2 1948

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

James Redman

Signed _____
Student Embalmer

Licensed Embalmer No. *4527*

P. O. Address *2201 S. Grand St.*

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.