

FILED AUG 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27994

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **7196**

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 5300 Arsenal St.		d. STREET ADDRESS (If rural, give location) 5300 Arsenal St.	

3. NAME OF DECEASED (Type or Print) a. (First) Patrick b. (Middle) J. c. (Last) Duffy	4. DATE OF DEATH (Month) (Day) (Year) August. 16, 1949
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH January. 5, 1884	9. AGE (In years last birthday) 65	IF UNDER 1 YEAR Months 7	IF UNDER 1 YEAR Days 11	IF UNDER 1 HR. Hours	IF UNDER 1 HR. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Man	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Ireland	12. CITIZEN OF WHAT COUNTRY? U. S.
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13a. FATHER'S NAME Patrick J. Duffy	13b. MOTHER'S MAIDEN NAME Mary Corcoran	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Bridget Leonard	ADDRESS 2131 East Fair Ave.
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 6 months
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ch. Myocarditis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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) 930
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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? 4222
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22. I hereby certify that I attended the deceased from **July 16, 1949** to **Aug 16, 1949**, that I last saw the deceased alive on **Aug 13, 1949**, and that death occurred at **5 A.** m., from the causes and on the date stated above.

23a. SIGNATURE Theresa Greener	(Degree or title)	23b. ADDRESS 4500 Belmont St	23c. DATE SIGNED 8/16/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE August 19, 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 REGISTRAR'S SIGNATURE AUG 18 1949 J. B. Sasater	25. FUNERAL DIRECTOR'S SIGNATURE Chas. F. Smith	ADDRESS 225 Union
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
X Write above of Ch. Myo

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.

Student
Student Embalmer

Signed Clement McGeary

Licensed Embalmer No. 3732

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.