

FILED OCT 7 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31738

State File No. _____

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **8140**

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

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	
c. LENGTH OF STAY (in this place) 4 mo		d. STREET ADDRESS (If rural, give location) 1383 Shawmut Pl	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John Hospital			
3. NAME OF DECEASED a. (First) Timothy b. (Middle) J c. (Last) English		4. DATE OF DEATH (Month) (Day) (Year) 9/17/49	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH About 1777
9. AGE (In years last birthday) 77	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auditor	10b. KIND OF BUSINESS OR INDUSTRY Real Estate	11. BIRTHPLACE (State or foreign country) Ireland	12. CITIZEN OF WHAT COUNTRY? U.S.A
13a. FATHER'S NAME Henry English	13b. MOTHER'S MAIDEN NAME Johanna Kelleher	14. NAME OF HUSBAND OR WIFE Nil	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME John J. Sheehan ADDRESS 5434 N. Kingsby.	
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.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arterio sclerotic cardiac mor. dis. INTERVAL BETWEEN ONSET AND DEATH 6-7 mo. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) None DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None	
19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) No	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 930	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 4:21	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from May 1949 , to Sept 17, 1949 , that I last saw the deceased alive on 9-17-49 , and that death occurred at 8:30 p.m. , from the causes and on the date stated above.			
23a. SIGNATURE John Hammond (Degree or title) M.D.		23b. ADDRESS 634 N. Grand	23c. DATE SIGNED 9/19/49
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9/21/49	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemt.	24d. LOCATION (City, town, or county) (State) St. Louis Mo
DATE REC'D BY LOCAL REG. SEP 20 1949	REGISTRAR'S SIGNATURE J.B. Laster	25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS 4415 Washington Blvd. Und 80	

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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 *J. W. M. Dinkley*

Licensed Embalmer No. *3653*

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.