

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **9915**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo 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 DePaul Hospital		d. STREET ADDRESS (If rural, give location) 2423 Bacon St.	

3. NAME OF DECEASED (Type or Print) a. (First) Margarita b. (Middle) c. (Last) Beirne		4. DATE OF DEATH (Month) (Day) (Year) Nov. 7 1951	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb. 27 1887
9. AGE (In years last birthday) 64		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country) Ireland
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME Patrick Madden	13b. MOTHER'S MAIDEN NAME Honora Higgens	14. NAME OF HUSBAND OR WIFE Dominick Beirne
15. WAS DECEASED EVER IN U. S. ARMY, NAVY, AIR FORCE, MARINE CORPS, OR COAST GUARD (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 496-22-1681	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Dominick Beirne 2423 Bacon St.

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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 5 days yrs. 6 mos.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) arterial coronary thrombosis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterio stenosis DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Polycythemia			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? H211

22. I hereby certify that I attended the deceased from **Sept. 7, 1951** to **Nov. 7, 1951**, that I last saw the deceased alive on **Nov. 7, 1951**, and that death occurred at **11:00 P.M.** from the causes and on the date stated above.

23a. SIGNATURE Arthur M. N. Sullivan	(Degree or title)	23b. ADDRESS 2202 University	23c. DATE SIGNED 11/8/51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 11/10/51	24c. NAME OF CEMETERY OR CREMATORY Calvary	24d. LOCATION (City, town, or county) (State) St. Louis Mo
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DATE REC'D BY LOCAL HEALTH DEPT. NOV 8 1951	REGISTRAR'S SIGNATURE J. Paul Smith M.D. R.P.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Sullivan Funeral Dir. 2849N. Euclid
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

2204-1000

CE 3995

12.30
AM

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.....

working under my personal supervision.

Student Embalmer No.....

Signed Francis Williamson

Signed.....
Student Embalmer

Licensed Embalmer No. 3565

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.