

STANDARD CERTIFICATE OF DEATH

16338

State File No.

FILED MAY 14 1953

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **3976**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY OR TOWN St. Louis		c. CITY OR TOWN St. Louis 2059	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Luke's Hospital		d. STREET ADDRESS (If rural, give location) 5565 Cabanne Ave.	

3. NAME OF DECEASED (Type or Print) Mary Walsh			4. DATE OF DEATH (Month) (Day) (Year) April 14, 1953		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Nov. 12, 1891		9. AGE (In years last birthday) 61
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Matron		10b. KIND OF BUSINESS OR INDUSTRY Private Schools		11. BIRTHPLACE (State or foreign country) St. Louis, Mo.	
12. CITIZEN OF WHAT COUNTRY? U.S.					

13a. FATHER'S NAME Thomas Cunningham		13b. MOTHER'S MAIDEN NAME Mary Unknown		14. NAME OF HUSBAND OR WIFE James	
---	--	---	--	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 488-30-9337	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Frances McDonald, 5472 Beacon			
---	--	---	--	--	--

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*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>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CA of gall bladder INTERVAL BETWEEN ONSET AND DEATH		
		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		

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? 155X	

22. I hereby certify that I attended the deceased from **3/22**, 1953, to **4/14**, 1953, that I last saw the deceased alive on **4/14**, 1953, and that death occurred at **12:30** m., from the causes and on the date stated above.

23a. SIGNATURE G. B. Raden (Degree or title) M.D.		23b. ADDRESS St. Louis, Mo.		23c. DATE SIGNED 4/15/53	
---	--	------------------------------------	--	---------------------------------	--

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4-17-53	24c. NAME OF CEMETERY OR CREMATORY Calvary	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		
---	--------------------------	---	---	--	--

DATE REC'D BY LOCAL REG. APR 16 1953	REGISTRAR'S SIGNATURE J. Earl Smith, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington Blvd.		
---	--	--	--	--	--

S.P. (Licensed Embalmer's Statement on Reverse Side)

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

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

John J. Harris

Signed.....
Student Embalmer

Licensed Embalmer No. 4108

P. O. Address 6 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.