

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **26122**
Registrar's No. **6107**

FILED JUL 31 1953

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 OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Hospt.		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) Anna Beirne		4. DATE OF DEATH (Month) (Day) (Year) 6/17/53	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH July 23 1880	
9. AGE (In years last birthday) 72		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (City and State or Foreign Country) England		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME James Weir		13b. MOTHER'S MAIDEN NAME Mary McDonald	
14. NAME OF HUSBAND OR WIFE James Beirne		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 Thomas Beirne	
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.		17. ADDRESS 1010a Hodiament Ave.	
19a. DATE OF OPERATION 6/17/53		19b. MAJOR FINDINGS OF OPERATION lymphosarcoma	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. ACCIDENT SUICIDE HOMICIDE (Specify)	
21a. 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) (Minute)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 2001		22. I hereby certify that I attended the deceased from 2-20 , 19 50 , to June 17 , 19 53 , that I last saw the deceased alive on June 17 , 19 53 , and that death occurred at 10:30 P.M. , from the causes and on the date stated above.	
23a. SIGNATURE B. G. Glassberg		23b. ADDRESS Mr. D. O. 1127 Pine St.	
23c. DATE SIGNED 6/18/53		24. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE 6/20/53		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	
24d. LOCATION (City, town, or county) (State) St. Louis, Missouri		25. FUNERAL DIRECTOR'S SIGNATURE Jos. W. Clark	
25. ADDRESS 1125 Hodiament Ave.		DATE REC'D BY LOCAL REG. JUN 19 1953	

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

1127
3
Crawford

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.....
Signature of Student Embalmer

Signed..... *John S. Pennell*
Licensed Embalmer No. *419*
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.