

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 37126

9974

BIRTH NO.		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No.	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis, Mo.</b>		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN <b>St. Louis,</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Johns, Hospital.</b>				e. STREET ADDRESS (If rural, give location) <b>9145 Dischinger Ct.</b>			
3. NAME OF DECEASED (Type or Print)		a. (First) <b>Thomas</b>	b. (Middle) <b>J.</b>	c. (Last) <b>Daly</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Oct. 18, 1953.</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>Nov. 28, 1886.</b>	9. AGE (in years last birthday) <b>66.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours   Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steamfitter</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <b>County Mayo, Ireland.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>unknown</b>		13b. MOTHER'S MAIDEN NAME <b>unknown.</b>		14. NAME OF HUSBAND OR WIFE <b>Anita Daly.</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>Nil.</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Anita Daly, 9145 Dischinger Court.</b>			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Acute Suppurative Appendicitis 8 days</b> ANTECEDENT CAUSES <b>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</b> DUE TO (b) <b>3) Peritonitis</b> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b>	
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)		21f. HOW DID INJURY OCCUR? <b>5501</b>	
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"/>					
22. I hereby certify that I attended the deceased from <b>11 Oct, 1953, to 18 Oct, 1953</b> , that I last saw the deceased alive on <b>18 Oct, 1953</b> , and that death occurred at <b>7:30 P.M.</b> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>W. J. Catoway M.D.</b>				23b. ADDRESS <b>2705 Clifton</b>		23c. DATE SIGNED <b>19 Oct 53</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>10-21-53</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery,</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>	
DATE REC'D BY LOCAL REG. <b>OCT 19 1953</b>		REGISTRAR'S SIGNATURE <b>Carl Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Albert H. Hoppe</b>		ADDRESS <b>4700 Washington.</b>	

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

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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.....  
Signature of Student Embalmer

Signed.....  


Licensed Embalmer No..... 470

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.