S. No. 300
10-48

FILED SEP 21 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31741

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 8220

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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 Mo b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis c. LENGTH OF STAY (in this place)	c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 16 St. Louis 2169
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Deaconess Hospital	d. STREET ADDRESS (If rural, give location) 3135 Gurney Ave.

3. NAME OF DECEASED (Type or Print)	a. (First) CATHERINE	b. (Middle) H.	c. (Last) DUFFY
4. DATE OF DEATH	(Month) Sept.	(Day) 5th	(Year) 1954
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married	8. DATE OF BIRTH March 23 ~~1893~~ 1891
9. AGE (In years last birthday) ~~61~~ 63	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis Mo.	12. CITIZEN OF WHAT COUNTRY?
13a. FATHER'S NAME Patrick Duffy	13b. MOTHER'S MAIDEN NAME Bridget Egan	14. NAME OF HUSBAND OR WIFE none	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Teresa Reese 3135 Gurney Ave.	

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
1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Intestinal Obstruction c̄ Gangrene	Oct 24 Hr
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Carcinoma of lower sigmoid	?
DUE TO (c)		
11. 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	20. AUTOPSY? YES ☑ NO ☐
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) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR? 153x

22. *I hereby certify that I attended the deceased from* Sept 4th, 1954, *to* Sept 5th, 1954, *that I last saw the deceased alive on* Sept 5th, 1954, *and that death occurred at* 12:20P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) A. G. Klein MD	23b. ADDRESS 2632 So Kingshighway	23c. DATE SIGNED 9-7-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9/8/54	24c. NAME OF CEMETERY OR CREMATORY Calvary	24d. LOCATION (City, town, or county) (State) St. Louis Mo.
DATE REC'D BY LOCAL REG. SEP 7 1954	REGISTRAR'S SIGNATURE J. Carl Smith MD MJB	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Sullivan's 2849 N. Euclid Ave.	

(Licensed Embalmer's Statement on Reverse Side)

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 Albert P. Mayfield

Licensed Embalmer No. 3077

P. O. Address.....

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.