

REC'D APR 1 1938 MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

8761
Do not use this space.

1. PLACE OF DEATH

(a) County _____ Registration District No. _____
 (b) Township _____ Primary Registration District No. _____ Registered No. **2350**
 (c) City **ST. LOUIS MO.** (d) Street No. **DE PAUL HOSPITAL** St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

MARY J. SOMERS, 562
 (a) Residence, No. **1502 MISSISSIPPI AV.** St. **23**
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **FEMALE** 4. COLOR OR RACE **WHITE** 5. ~~SINGLE, MARRIED, WIDOWED, OR DIVORCED~~ **WIDOW**
 5A. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF (OR) WIFE OF **JOHN SOMERS**
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **MAY 18-1872**
 7. AGE YEARS **65** MONTHS **9** DAYS **18** If LESS than 1 day, _____ hrs. or _____ min.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as saw mill, bank, etc. **HOUSEKEEPER**
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **MARCH 8** 19**38**
 22. I HEREBY CERTIFY, That I attended deceased from **March 1**, 19**38**, to **March 8**, 19**38**.
 I last saw him alive on **March 7**, 19**38**. Death is said to have occurred on the date stated above, at **8** ¹/₄ m.
 The principal cause of death and related causes of importance were as follows:
Cerebral Haemorrhage
 Date of onset **3/5/38**

Other contributory causes of importance:
Pulmonary Edema caused by cerebral hemorrhage no Prev. from Tubercular

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? **yes**

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify _____
 (Signed) **M. S. Doyle** M. D.
 (Address) **Metropolitan Bldg**

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **MISSOURI**
 FATHER 13. NAME **JOHN BRADY**
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **IRELAND**
 MOTHER 15. MAIDEN NAME **MARY DOLAN**
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **IRELAND**
 17. INFORMANT (ADDRESS) **MRS. ANN BEEBE, 1502 MISSISSIPPI AV.**
 18. BURIAL, CREMATION, OR REMOVAL PLACE **CALVARY CEM.** DATE **MARCH 10 1938**
 19. FUNERAL DIRECTOR (ADDRESS) **E. J. Schmur, 3125 Lafayette Ave**
 20. FILED **WAR 9 1938** **J. H. Bredeck** Local Registrar.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

STATEMENT BY LICENSED EMBALMER

I, Joseph Kollmer, Licensed Embalmer No. 4014
hereby certify that the body recorded on the reverse side of this certificate was embalmed by Joseph Kollmer
..... L. E.

No. or by Registered Apprentice No.
working under my personal supervision.

Signed Joseph Kollmer
Licensed Embalmer No. 4014

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.)