

REC'D MAY 10 1938

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

13098

Do not use this space.

1. PLACE OF DEATH

(a) County Registration District No. **791**
(b) Township Primary Registration District No. **1003**, Registered No. **3702**
(c) City **St. Louis, Mo.** (d) Street No. **City Hospital #1** 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 **Pat Dacey 200**

(a) Residence, No. **No home** St. **X**
(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 **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Single**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **?**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
55

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Laborer**
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) **Mo.** (STATE OR COUNTRY)13. NAME **?**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME **?**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT **Hosp. info. M. Williams** (ADDRESS) **City Hospital #1**

18. BURIAL, CREMATION, OR REMOVAL

PLACE **Calvary** DATE **April 21, 1938**19. FUNERAL DIRECTOR (NAME) (ADDRESS) **J. H. Hebbert**
2842 Meigs20. FILED **APR 21 1938** **J. P. Breck** Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **4/20/38**, 1922. I HEREBY CERTIFY, That I attended deceased from **4/18/38**, 19, to **4/20/38**, 19.I last saw him alive on **4/20/38**, 19. Death is said to have occurred on the date stated above, at **5:15 A.M.**

The principal cause of death and related causes of importance were as follows:

Uremia
Appendiceal abscess with
generalized peritonitis
Benign hyper trophy of prostate
Urinary retention

Date of onset

Other contributory causes of importance:

Generalized arteriosclerosis
Atherosclerotic heart disease

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) **J. W. Maxwell**, M. D.(Address) **1515 Lafayette**

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,

No Embalming, or by

Registered Apprentice No., working under my personal supervision.

Signed.....

Licensed Embalmer No.

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, above space should be left blank.