

NOV 22 1938  
Harrison & Sheahan

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

37748  
Do not use this space.

791

1008

10075

1. PLACE OF DEATH

(a) County..... Registration District No.....  
(b) Township..... Primary Registration District No.....  
(c) or City St. Louis (d) Street No. City Hospital No. 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 35 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Edward Carmody  
(a) Residence, No. 731 South Broadway (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11/21/38

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

22. I HEREBY CERTIFY, That I attended deceased from 11/17/38 to 11/21/38

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 28, 1872

I last saw him alive on 11/21/38, 19... Death is said to have occurred on the date stated above, at 8.45 a

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
66 1 23

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

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. nil  
10. Date deceased last worked at this occupation (month and year)  
11. Total time (years) spent in this occupation

Hypertensive Heart Disease with congestive failure  
Date of onset 9/5/38

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Springfield Illinois

Other contributory causes of importance:  
Acute alcoholism  
Chronic alcoholism

FATHER 13. NAME Dan Carmody  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

Name of operation..... Date of.....

MOTHER 15. MAIDEN NAME Margaret Fitzgibbons  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

What test confirmed diagnosis?..... Was there an autopsy? no

17. INFORMANT (ADDRESS) Hosp. Info R. Kent

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)

18. BURIAL, CREMATION, OR REMOVAL PLACE Calvary Cemt DATE 11/22/38

Specify whether injury occurred in industry, in home, or in public place.

19. FUNERAL DIRECTOR (ADDRESS) Harrison & Sheahan Und 4415 Washington Blvd

Manner of injury..... Nature of injury.....

20. FILED NOV 22 1938 J. Bredeck Local Registrar.

24. Was disease or injury in any way related to occupation of deceased? No, specify..... (Signed) Dr. Maxwell, M. D. (Address) City Hospital No. 1

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

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

Raymond E. Herke, License # 3785  
Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed

Rex C. Campbell

Licensed Embalmer No. 3881

P. O. Address St. Louis, Mo.

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.