

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

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.

REG'D SEP 14 1939 **791**

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH: **1008**

(a) County _____

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: City Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 27 Days
(Specify whether years, months or days)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 1

(c) City or town St. Louis 23
(If outside city or town limits, write "RURAL")

(d) Street No. 2421 S. 12th St.
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

8. (a) PRINT FULL NAME THOMAS Cooney 500

3. (b) If veteran, name war NONE 3. (c) Social Security No. NONE

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife Nellie 6. (c) Age of husband or wife if alive _____ years
(Day) (Year)

7. Birth date of deceased April 25 1865
(Month) (Day) (Year)

8. AGE: Years 74 Months 3 Days 13 If less than one day _____ hr. _____ min.

9. Birthplace Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Steamboat CAPTAIN

11. Industry or business River Steamers

MOTHER FATHER { 12. Name UNKNOWN 9

13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

14. Maiden name Unknown 9

15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Colbyford Jackson

(b) Address 3226 Cherokee

17. (a) Burial (b) Date thereof Aug 11, 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director W. J. ... Co.

(b) Address 2929 S. Jefferson Ave

19. (a) AUG 10 1939 (b) J. A. ...
(Official date of registration) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 8, year 1939 hour 11:06 minute A. M.

21. I hereby certify that I attended the deceased from July 13, 1939, to August 8, 1939.

that I last saw him alive on August 8, 1939 and that death occurred on the date and hour stated above.

Immediate cause of death Capillary carcinoma of urinary bladder. Duration _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature J. E. Tom Keneel, (M. D. or other)

Address City Hospital Date signed 8/8/39

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 _____

Paul A. Shanklin

Registered Apprentice No. _____

working under my personal supervision.

Signed _____

Paul A. Shanklin

Licensed Embalmer No. *3472*

P. O. Address *2999 S. Jefferson*

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.