Dr. Crecelius

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 30716

Registration District No. 1903 (OCT 14 1939) 791 Primary Registration District No. ____ Registrar's No. ____

1. PLACE OF DEATH: 2

(a) County ____

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

(c) Name of hospital or institution: 3129 Rolla Pl (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days) In this community ____

2. USUAL RESIDENCE OF DECEASED: 1

(a) State ____ (b) County ____

(c) City or town St. Louis. Cmo (If outside city or town limits, write "RURAL") NO

(d) Street No. 3129. Rolla. Place (If rural, give location)

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

3. (a) PRINT FULL NAME MARGARET - DUFFEY

3. (b) If veteran, name war ____ 3. (c) Social Security No. ____

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

6. (b) Name of husband or wife unk. 6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased Aug (Month) 12 (Day) 1869 (Year)

8. AGE: Years 70 Months ____ Days 26 If less than one day ____ hr. ____ min.

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

10. Usual occupation Home. Wife 3

11. Industry or business ____

FATHER 12. Name Peter Kenney 5

13. Birthplace Ireland (City, town, or county) ____ (State or foreign country) E

MOTHER 14. Maiden name Margaret Burn

15. Birthplace Ireland (City, town, or county) ____ (State or foreign country)

16. (a) Informant's own signature John. Tracy

(b) Address 3129. Rolla. Place

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

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Edw. F. Howard & Son

(b) Address 4212. St. Louis ave

19. (a) SEP 8 1939 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month 9 day 7 year 1939 hour 7 minute A. M.

21. I hereby certify that I attended the deceased from 1935, 19____, to 9-7-, 19 39, that I last saw her alive on 9-7-, 19 39 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Nephritis caused by	4 days
Due to: Hyper Tension	3-5 yr
Due to: Chronic Cardio-vascular disease	
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations ____ Of autopsy None

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? ____ (Specify type of place)

While at work ____ (e) Means of injury ____

23. Signature Brian D. Cuelius (M. D. or other) M.D.

Address 3220 S. Grand Date signed 9.7.39

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.

(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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Edw. F. Howard

Licensed Embalmer No. 1443

P. O. Address 4212. St. Louis ave

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.