

NOV 13 1939

791

Registration District No.

Primary Registration District No.

Registrar's No.

8625

1. PLACE OF DEATH: 1008  
 (a) County 2  
 (b) City or town Saint Louis  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: 4470 Laclede ave.  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
 In this community Life years, months or days

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County 1  
 (c) City or town Saint Louis 19  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 4470 Laclede (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Mary Elizabeth Martin (Holleran)  
 (b) If veteran, name war no  
 (c) Social Security No. 465

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Oct day 7  
 year 1939 hour 10 minute 10 P. M.  
 21. I hereby certify that I attended the deceased from Sept 10<sup>th</sup> 39  
 \_\_\_\_\_, 1939, to Oct 7, 1939

4. Sex Female 5. Color or race White  
 6. (a) Single, widowed, married, divorced Widowed  
 6. (b) Name of husband or wife Joseph V. Martin  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased May 30 1866  
 (Month) (Day) (Year)

that I last saw her alive on Oct 7 1939  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death Chronic interstitial nephritis Duration 10 yrs

8. AGE: Years Months Days If less than one day  
73 4 7 hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

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

10. Usual occupation Housework

11. Industry or business At Home

FATHER { 12. Name John Holleran  
 13. Birthplace Ireland  
 (City, town, or county) (State or foreign country)

MOTHER { 14. Maiden name Mary Hassion  
 15. Birthplace Ireland  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature \_\_\_\_\_  
 (b) Address 4470 Laclede

17. (a) Burial (b) Date thereof 10/10/39  
 (Burial, cremation, etc.) (Month) (Day) (Year)  
 (c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Thos J Finnan  
 (b) Address 1519 So. Grand Blvd.

19. (a) OCT 9 1939  
 (Date received local registrar) (Signature)

Other conditions none  
 (Include pregnancy within 3 months of death)  
 Major findings: none  
 Of operations none  
 Of autopsy none

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. H. Simon M.D. (M. D. or other) \_\_\_\_\_  
 Address 4000 Lechman Date signed \_\_\_\_\_

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.

1 X1911

**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

*Thomas J. Fernald*

Licensed Embalmer No. *1197*

P. O. Address *1579 Grand*

**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.**