

NOV 13 1939

Registration District No. _____

Primary Registration District No. _____

Registrar's No. 9524

1. PLACE OF DEATH:

(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:
3952 Cleveland 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 _____
years, months or days)

8. (a) PRINT FULL NAME Julia Whelan 4570

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 Widow

6. (b) Name of husband or wife Edward F. Whelan 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased August 22 1873
(Month) (Day) (Year)

8. AGE: Years <u>66</u>	Months <u>2</u>	Days <u>16</u>	If less than one day hr. _____ min. _____
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9. Birthplace Saint Louis, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housekeeper

11. Industry or business _____

MOTHER FATHER { 12. Name John Dillon

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

14. Maiden name Arbia
(City, town, or county) (State or foreign country)

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

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

(b) Address 3952 Cleveland

17. (a) Burial (b) Date thereof Nov 9, 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director E. J. Schauer

(b) Address 3125 Lafayette Ave.

19. (a) NOV 8 1939 (b) J. F. Kredetz
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town Saint Louis, 17
(If outside city or town limits, write "RURAL")
(d) Street No. 3952 Cleveland Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 7th
year 1939 hour 1:10 minute A M.

21. I hereby certify that I attended the deceased from Oct 31 to Nov 7 1939 that I last saw her alive on Nov 7 and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Infarction

Due to _____

Due to _____

Other conditions (Include pregnancy within months of death) _____

Major findings: Of operations _____

Of autopsy _____

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) _____ (Means of injury)

23. Signature J. M. A. New (M. D. or other) _____

Address 446 S. Grand Date signed Nov 7-39

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WHILE FILLING IN USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

I X1051

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.

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.....

Joe B. Wallmer

Licensed Embalmer No. *4014*

P. O. Address *3125 Lafayette Ave*

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.