

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

JAN 12 1940

Registration District No. 1003

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 41334

Registrar's No. 10457

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County St. Louis, Missouri
(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 Sanitarium
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 yrs. 7 mos. 24
58 yrs. (Specify whether years, months or days)

3. (a) PRINT FULL NAME Mary Doody

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

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

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

7. Birth date of deceased January 6th, 1881
(Month) (Day) (Year)

8. AGE: Years 58 Months 10 Days 29 If less than one day hr. _____ min. _____

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

10. Usual occupation None

11. Industry or business _____

12. Name Thomas Doody

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

14. Maiden name Mary Dillon

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

16. (a) Informant's own signature Cater South

(b) Address 5400 Grand

17. (a) Burial (b) Date thereof 11/7/39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cem.

18. (a) Signature of funeral director Harrigan & Sheahan Und Co

(b) Address 4415 Washington Blvd.

19. (a) DEC 6 1939 (b) J.F. Brudick
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis, 16
(If outside city or town limits, write "RURAL")
Date of death Little Sisters of the Poor
3400 S. Grand Blvd. (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 5
year 1939 hour 7:50 minute a M. M.

21. I hereby certify that I attended the deceased from July 1, 1938 to Dec. 5, 1939
that I last saw her alive on Dec 5, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Duration 11-28-39

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 8 months of death)

Major findings: Of operations

Of autopsy No

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.F. Brudick (M. D. or other) _____

Address _____ Date signed _____

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 *Homer W. Fritz*

Licensed Embalmer No. *3882*

P. O. Address.....

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.