

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

MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

State File No. 41898
11021
 Registrar's No.

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:
 (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, #1
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 Mo. 12 Days
Abt. 40 yrs. (Specify whether years, months or days)
 In this community _____

3. (a) PRINT FULL NAME Kate Walsh H20
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____
 4. Sex F 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 Abt. 1854
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr. _____ min.
Abt. 85

9. Birthplace Ireland
(City, town, or county) (State or foreign country)
 10. Usual occupation Retired Music teacher
Teaching

11. Industry or business _____
 12. Name Unknown
 13. Birthplace Unknown
(City, town, or county) (State or foreign country)
 14. Maiden name Unknown
 15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature S. M. White
 (b) Address 1128 N. 4th St.
 17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 27, 1939
(Month) (Day) (Year)
 (c) Place: burial or cremation Calvary Cemetery
 18. (a) Signature of funeral director Bessie Nichols
 (b) Address 1421 Union Blvd

19. (a) DEC 26 1939 (b) J. S. Biddle
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County 1
 (c) City or town St. Louis, 21
(If outside city or town limits, write "RURAL")
 (d) Street No. 1411 Hogan St.
(If rural, give location)
 (e) If foreign born, how long in U. S. A. Abt. 55 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 24,
 year 1939 hour 5:40 minute A. M.
 21. I hereby certify that I attended the deceased from November
13, 19 39 to December 24, 19 39
 that I last saw her alive on December 24, 19 39
 and that death occurred on the date and hour stated above.

Immediate cause of death arteriosclerosis
Heart Disease
 Duration 1 yr
 Due to _____
 Due to _____

Other conditions Range of 3rd & 4th Rose Lane
(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 Walter Ford (M. D. or other) _____
 Address 1515 Lafayette, 12/26/39

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *L. M. White*
Licensed Embalmer No. *29721*
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.