

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.

FILED MAR 12 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 4628
Registrar's No. 1458

Registration District No. 701

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3408 A. St. Vincent Ave
(If not in hospital or institution, write street number or location) 2
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 3408 A. St. Vincent Ave (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Nellie Toole

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 Single
6. (b) Name of husband or wife **** 6. (c) Age of husband or wife if alive **** years
7. Birth date of deceased Unknown
(Month) (Day) (Year)

8. AGE: Years About 72 Months _____ Days _____ If less than one day hr. _____ min. _____

9. Birthplace Missouri (City, town, or county) (State or foreign country) 0

10. Usual occupation Housework 5

11. Industry or business _____ 3

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

MOTHER FATHER { 14. Maiden name Bridget Calihan (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 Wm. Murphy
(b) Address 3451 St. Vincent

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 9 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Peetz Brothers
(b) Address 3029 La ayette Ave

19. (a) FEB 13 1940 (Date received local registrar) (b) J. J. ... (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 3408 A. St. Vincent Ave
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6th day February
year 1940 hour 7:00 minute PM M.

21. I hereby certify that I attended the deceased from January 2, 1938 to February 6, 1940, that I last saw her alive on February 6, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
<u>Chronic Myocarditis</u>	<u>2 yrs</u>
Due to <u>Chronic Bronchiectasis</u>	<u>?</u>
Due to _____	_____
Other conditions <u>None</u> (Include pregnancy within 3 months of death)	_____
Major findings: Of operations <u>None</u>	PHYSICIAN _____
Of autopsy <u>None</u>	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) (a) Means of injury _____
28. Signature R. Julio Lopez Koller (M. D. or other M.D.)
Address 2603 Cherokee St Date signed 2/8/40

2 to 4
7 to 8

1A58

1A58

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 Frank J. Quinn

Licensed Embalmer No. 4445

P. O. Address Wolcott, Me

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.