

WHILE FLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

Registration District No. 791 Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County St. Louis Mo

(b) City or town St. Louis Mo

(c) Name of hospital or institution: 5140 Terry Ave
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Life
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED

(a) State St. Louis (b) County Mo

(c) City or town St
(If outside city or town limits, write "RURAL")

(d) Street No. 5140 Terry Ave
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

In this community _____ years, months or days

3. (a) PRINT FULL NAME MARY ANN GADALL

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

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

6. (b) Name of husband or wife Michael Age of husband or wife if alive 54 years

7. Birth date of deceased 9-16-1889
(Month) (Day) (Year)

8. AGE: Years 50 Months 5 Days 12 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business Home wife

MOTHER FATHER

12. Name Thomas Walsh

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

14. Maiden name Ellen Walsh

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

16. (a) Informant's own signature Michael Gadall
(b) Address 5140 Terry Ave

17. (a) Denial (b) Date thereof 2/21/40
(Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director William H. ...
(b) Address 2849 No. Euclid Ave

19. (a) FEB 20 1940 (b) J.P. ...
(Date received local registrar) (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 18 year 1940 hour 12 minute 05 P. M.

21. I hereby certify that I attended the deceased from Feb 3rd, 1940, to Feb 18th, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death Acute dilatation of heart

Due to Ch. Myocarditis

Due to Arteriosclerosis

Other conditions (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 James O. ... (M. D. or other)
Address 2849 No. Euclid Ave Date signed 2/19/40

283 of 284 - 30/11/1911

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. *10*

working under my personal supervision.

Signed

Albert Mayfield

Licensed Embalmer No.

3077

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.