

1. PLACE OF DEATH:

(a) County ST. LOUIS CITY  
 (b) City or town \_\_\_\_\_  
 (c) Name of hospital or institution: ST. LUKES HOSPITAL  
 (If not in hospital or institution, write street number and location)  
 (d) Length of stay: In hospital or institution 28 HOURS  
 (Specify whether \_\_\_\_\_)  
 In this community \_\_\_\_\_  
 years, months or days

3. (a) PRINT FULL NAME MARY FLANNERY 456  
 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 \_\_\_\_\_  
 6. (b) Name of husband or wife \_\_\_\_\_  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased APRIL 16, 1940  
 (Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days 1 If less than one day 4  
0 0 1 28 hr. 30 min.

9. Birthplace ST. LOUIS MO.  
 (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_  
 11. Industry or business \_\_\_\_\_

FATHER { 12. Name HARRY W. FLANNERY  
 13. Birthplace PENNSYLVANIA  
 (City, town, or county) (State or foreign country)  
 MOTHER { 14. Maiden name RUTH CARMODY  
 15. Birthplace WETERELEIT MICHIGAN  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Harry W. Flannery  
 (b) Address 910 Trinity Ave W. City  
 17. (a) BURIAL (b) Date thereof 4-18-40  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY CEMETERY  
 18. (a) Signature of funeral director Arthur J. Donnelly  
 (b) Address 3840 Lindell Blvd  
 19. (a) APR 18 1940 (b) \_\_\_\_\_  
 (Date received local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County ST. LOUIS  
 (c) City or town UNIVERSITY CITY NR  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 910 TRINITY AVE  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 17  
 year 1940 hour 3:30 minutes \_\_\_\_\_ P. M.  
 21. I hereby certify that I attended the deceased from BIRTH  
APRIL 16, 1940 to APRIL 17, 1940;  
 that I last saw her alive on APRIL 17, 1940;  
 and that death occurred on the date and hour stated above.

Immediate cause of death RESPIRATORY FAILURE Duration \_\_\_\_\_

Due to PREMATURITY

Due to \_\_\_\_\_

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 Regina N. Hamilton (M. D. or other) MD  
 Address St. Luke's Hospital Date signed 4-17-40

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.

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**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.....

*Stanley Marshall*

Licensed Embalmer No.....

*2868*

P. O. Address.....

*3840 Lindell*

**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.**