

No. 2 -
11-10-39
4-17-39
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FILED MAY 15 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

16157

State File No.

Registration District No. 784

Primary Registration District No. 200

Registrar's No. 927

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Walleston
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1700 Lucas - Hunt Road 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community 50 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town Walleston
(If outside city or town limits, write "RURAL")
(d) Street No. 1700 Lucas - Hunt Road.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12th day May
year 1940 hour 5:30 minute A.M.

21. I hereby certify that I attended the deceased from Jan 10th 1940, to 26 April 1st 1940;
that I last saw her alive on 26 April 1/1940 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death chronic indolent dilat. mitral insufficiency 5 yrs
Duration _____

Due to _____
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? 787 (Specify type of place) _____
(e) Means of injury _____

23. Signature Dr. H. O. Oesper (M. D. or other) _____
Address 314 E. Olive St. Date signed 5/13/40

8. (a) PRINT FULL NAME Katherine Clark 462

3. (b) If veteran, name war None 8. (c) Social Security No. None

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

6. (b) Name of husband or wife John P. 6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased Jan. 29 1873
(Month) (Day) (Year)

8. AGE: Years 67 Months 3 Days 13 If less than one day _____ hr. _____ min.

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

10. Usual occupation House work

11. Industry or business Home

12. Name John Leonard

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

14. Maiden name Katherine Rafferty

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

16. (a) Informant Francis Clark

(b) Address 3652 Hickory St.

17. (a) Burial (b) Date thereof May 15 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Cullen & Kelly

(b) Address 1416 N. Taylor Ave.

19. (a) MAY 12 1940 (Date received) [Signature] (Registrar's signature)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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

Clement McManis

Licensed Embalmer No. *3732*

P. O. Address

St. Louis

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.