

No. 2  
11-10-39  
5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

26751

State File No. \_\_\_\_\_

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **6647**

**1. PLACE OF DEATH:**

(a) County St. Louis Mo.

(b) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1239 Amherst place. 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 \_\_\_\_\_  
years, months or days

**2. USUAL RESIDENCE OF DECEASED:**

0 Mo.

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_

(c) City or town St. Louis 5  
(If outside city or town limits write "RURAL")

(d) Street No. 1239 Amherst Place.  
(If rural, give location)

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

**3. (a) PRINT FULL NAME** Margaret Quinn 507

**3. (b) If veteran,** name war \_\_\_\_\_ **3. (c) Social Security** No. \_\_\_\_\_

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

**6. (b) Name of husband or wife** John J. Quinn **6. (c) Age of husband or wife if alive** 70 years

**7. Birth date of deceased** May 5, 1873  
(Month) (Day) (Year)

<b>8. AGE:</b>	Years	Months	Days	If less than one day
<u>67</u>		<u>2</u>	<u>28</u>	hr. _____ min. _____

**9. Birthplace** Washington D. C.  
(City, town, or county) (State or foreign country)

**10. Usual occupation** Housewife

**11. Industry or business** \_\_\_\_\_

**MOTHER FATHER**

**12. Name** Michael Keough

**13. Birthplace** Ireland 5  
(City, town, or county) (State or foreign country)

**14. Maiden name** Margaret Galvin 5  
(City, town, or county) (State or foreign country)

**15. Birthplace** Ireland 5  
(City, town, or county) (State or foreign country)

**16. (a) Informant** Frank Quinn

**(b) Address** 1239 Amherst Place

**17. (a) Burial** Calvary **(b) Date thereof** 8/6/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

**(c) Place: burial or cremation** \_\_\_\_\_

**18. (a) Signature of funeral director** Sullivan

**(b) Address** 2849 N. Euclid

**19. (a) AUG 5 1940** **(b)** \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month Aug day 3  
year 1940 hour \_\_\_\_\_ minute 20 P. M.

**21. I hereby certify that I attended the deceased from** 3-17 1936 to 8-2 1940  
that I last saw her alive on 8-3 1940  
and that death occurred on the date and hour stated above.

**Immediate cause of death** Chronic bronchitis

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

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

**Other conditions** \_\_\_\_\_  
(Include pregnancy within 3 months of death)

**Major findings:**

**Of operations** \_\_\_\_\_

**Of autopsy** \_\_\_\_\_

**Duration** \_\_\_\_\_

**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?** \_\_\_\_\_

**23. While at work?** \_\_\_\_\_ **(Specify type of place)** \_\_\_\_\_ **(b) Means of injury** \_\_\_\_\_

**28. Signature** W W White **(M. D. or other)** MD

**Address** 3214 Euclid **Date signed** 8-5-40

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

FEB 2 1943

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 Alber May

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.