

27405

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED SEP 25 1940

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 7301

1. PLACE OF DEATH:

(a) County ST. LOUIS
 (b) City or town ST. LOUIS
 (c) Name of hospital or institution St. Mary's Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 47
 (Specify whether _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County _____
 (c) City or town ST. LOUIS - 20
 (If outside city or town limits, write "RURAL")
 (d) Street No. 2321 1/2 HOWARD ST.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A? _____ years.

3. (a) PRINT FULL NAME KATE WILLOUGHBY

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 MARRIED

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

7. Birth date of deceased JAN 17 1866
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>74</u>	<u>7</u>	<u>13</u>	hr. min.

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

10. Usual occupation AT HOME

11. Industry or business _____

MOTHER FATHER { 12. Name JAMES HERON
 13. Birthplace IRELANDS
 (City, town, or county) (State or foreign country)
 14. Maiden name MARY Unknown
 15. Birthplace IRELAND
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Kate Wiloughby

(b) Address 2321 1/2 Howard St -

17. (a) Burial (b) Date thereof 9-2-40
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peter's Cemetery

18. (a) Signature of funeral director Shepard Funeral Home

(b) Address 1167 Hamilton Ave.

19. (c) AUG 30 1940
 (Date received local registrar's certificate)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUG. day 30 - 1940
 year _____ hour 6:00 minute 15 M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw him alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral
 Due to _____
 Due to _____
 Other conditions apoplexy
 (Include pregnancy within 3 months of death)
 Major findings: _____
 Of operations gna
 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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

28. Signature John M. Leeson (M. D. or other) _____
 Address Deputy Date signed _____

WHILE I REMAIN 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.

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 J. G. Sullivan

Licensed Embalmer No. 1122

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.