

Registration-District No. **791**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

City or town **ST. LOUIS**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Alexian Brothers Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **9 months**
(Specify whether years, months or days)
In this community _____

3. (a) PRINT FULL NAME **Joseph J. Quinn**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **NONE**

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **widowed**
6. (b) Name of husband or wife **Mary McGrath** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Dec 25 1964**
(Month) (Day) (Year)

8. AGE: Years **74** Months **10** Days **17**
If less than one day hr. _____ min. _____

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

10. Usual occupation **Undertaker**

11. Industry or business **Undertaker**

12. Name **Patrick Quinn**

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

14. Maiden name **Katherine McCaffery**
(City, town, or county) (State or foreign country)

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

16. (a) Informant **Joseph J. Quinn**

(b) Address **1389 N. Union**

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

(c) Place: burial or cremation **Calvary Cem.**

18. (a) Signature of funeral director **Joseph Quinn**

(b) Address **1389 N. Union**

19. (a) **NOV 15 1940** (b) **J. J. Bruders**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
(c) City or town **ST. LOUIS**
(If outside city or town limits, write "RURAL")
(d) Street No. **1389 N. Union**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **12**
year **1940** hour **3** minute **54 P.M.**

21. I hereby certify that I attended the deceased from **Feb 8 1940** to **Nov 12 1940**
and that death occurred on the date and hour stated above. **Nov 11 1940**

Immediate cause of death **Myocarditis Chr**
Atherosclerosis

Due to **Smility**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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 **J. J. Bruders** (M. D. or other) **MD**
Address **5875 Elm** Date signed **11/13/40**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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 _____

Licensed Embalmer No. 1591

P. O. Address: 4106 9th Btwn

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, fact should be so stated above.