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10-39
7-39
K21492

Registration District No. 784

Primary Registration District No. 200

State File No. _____

Registrar's No. 2188

1. PLACE OF DEATH:

(a) County ST. LOUIS

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

(c) Name of hospital or institution: ROBERT KOCH HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 316 days
(Specify whether)

In this community LIFE
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County ST. LOUIS

(c) City or town ST. LOUIS
(If outside city or town limit, write "RURAL")

(d) Street No. 5383 NORTH LAND
(If rural, give location)

(e) If foreign born, how long in U. S. A. 0 years.

3. (a) PRINT FULL NAME THOMAS EDWARD WALSH

3. (b) If veteran, name war NONE

3. (c) Social Security No. 490-01-2403

MEDICAL CERTIFICATION:

20. DATE OF DEATH: Month NOVEMBER Day 19th Year 1940 hour 5 minute 15 P.M.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced MAR

6. (b) Name of husband or wife MARY F. WALSH

6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased JUNE 4 1874
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from JANUARY 3 1940 to NOVEMBER 19 1940 that I last saw him alive on NOVEMBER 19 1940 and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>66</u>	<u>5</u>	<u>15</u>	hr. _____ min.

Immediate cause of death CHRONIC PULMONARY TUBERCULOSIS

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

Due to _____

Due to ST. I.

10. Usual occupation ELECTRICIAN

Other conditions ST. I.
(Include pregnancy within 3 months of death)

MOTHER FATHER

11. Industry or business _____

12. Name THOMAS PATRICK WALSH

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

14. Maiden name MARGARET STONE

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

Major findings: _____

Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Koch RECORDS

(b) Address _____

17. (a) BURIAL (b) Date thereof 11/23/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY

18. (a) Signature of funeral director [Signature]

(b) Address 2117 E. GRAND BLVD

19. NOV 21 1940 (Date received local registrar) (b) [Signature] (Registrar's signature)

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? NO
(Specify type of place)

While at work? _____ (c) Means of injury _____

23. Signature [Signature] (M. D. or other) [Signature]

Address Koch Hospital Date signed 11/23/40

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

MAY 25 1948

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

Frank A. Moore

Licensed Embalmer No. *3041*

P. O. Address *2117 E. 4th*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.