

STANDARD CERTIFICATE OF DEATH

State File No. **40934**

791

Primary Registration District No. **1003**

Registrar's No. **10705**

Registration District No. _____

Primary Registration District No. _____

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: 2118 Mullanphy
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 (Specify whether Life)
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County _____
(c) City or town St. Louis 20
(If outside city or town limits, write "RURAL")
(d) Street No. 2232 Mullanphy
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME

MARY FRANCES DEVINE

MEDICAL CERTIFICATION

3. (b) If veteran, name war _____ No. _____
8. (c) Social Security No. _____
4. Sex Female 5. Color White 6. (a) Single, widwed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Dec 30, 1867
(Month) (Day) (Year)

20. DATE OF DEATH: Month 12 day 26
year 1940 hour 9 minute 30 A.M.
21. I hereby certify that I attended the deceased from June 3
1937 19 to Dec 19 1940
that I last saw h.e. alive on _____ 19
and that death occurred on the date and hour stated above.

8. AGE: Years 73 Months 9 Days 04 If less than one day _____ min.
9. Birthplace St. Louis Mo
(City, town or county) (State or foreign country)

Immediate cause of death Myocardial Failure of Chronic myocarditis
Due to hypertension or debility
Due to _____

10. Usual occupation Housekeeper

Other conditions (Include pregnancy within 3 months of death) 93C

MOTHER FATHER
11. Industry or business _____
12. Name John Devine
13. Birthplace Ireland
14. Maiden name Margaret McHugh
15. Birthplace Ireland
(City, town or county) (State or foreign country)

Major findings: Of operations None
Of autopsy None
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant Mary Nolan
(b) Address 3108 No 54th
17. (a) Burial (b) Date thereon 12/28/40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Cabury

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? _____

18. (a) Signature of funeral director J. T. Bredich
(b) DEC 27 1940
19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place) (c) Means of injury St. John's Hospital Clinic
23. Signature E. J. Call (M. D. or other) _____
Address 825A Manchester Date signed _____

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

W. B. ...

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 _____

Albert Mayfield
3077

Licensed Embalmer No. _____

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.