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X2315

JAN 8 1947 **84**
Registration District No. _____

Primary Registration District No. **106**

Registrar's No. **2442**

1. PLACE OF DEATH
 (a) County **St Louis**
 (b) City or town **Kirkwood MO**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution **St Agnes Nursing Home**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **8 Months**
 (Specify whether years, months or days) **3**

3. (a) PRINT FULL NAME **Mary Van Graafeiland**
 3. (b) If veteran, name war **no**
 3. (c) Social Security No. **no**

4. Sex **female** 5. Color or race **white**
 6. (a) Single, widowed, married, divorced **married**
 6. (b) Name of husband or wife **Rudolph**
 6. (c) Age of husband or wife if alive **84** years
 7. Birth date of deceased **Sept. 28, 1857**
 (Month) (Day) (Year)

8. AGE: Years **83** Months **2** Days **25**
 If less than one day hr. _____ min. _____

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

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **Martin Whalen**

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

14. Maiden name **Unknown**

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

16. (a) Informant **Rudolph Van Graafeiland**

(b) Address **St. Agnes Nursing Home**

17. (a) **burial** (b) Date thereof **12/27/40**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **Oscar J. Hoffmeister**

(b) Address **4016 Chippewa Street.**

19. (a) **DEC 26 1940** (b) **TR Meyer**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo** (b) County _____
 (c) City or town **Kirkwood**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **Woodlawn & Manchester**
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **23**
 year **1940** hour **4** minute **P.** M.

21. I hereby certify that I attended the deceased from **Nov. 23, 1940**
 to **Dec. 23 - 1940**
 that I last saw her alive on **Dec. 23 - 1940**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Arterio-sclerosis**
 Duration **Chronic**

Due to **Senility 97**

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
 Of autopsy _____

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 _____

23. Signature **D. L. Jennings** (M. D. or other) _____
 Address **4660 Maryland** Date signed **12-26-40**

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

MOTHER FATHER

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 Ernest W. Spillers

Licensed Embalmer No. 4080

P. O. Address 3747 Dunnic

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.