

FILED MAR 17 1942 791

State File No. 1675

Registration District No. 1

Primary Registration District No. 100

Registrar's No.

1. PLACE OF DEATH:

(a) County.....**St. Louis**
 (b) City or town.....**St. Louis**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. John's Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution.....**1-Mon.**
 (Specify whether
 In this community
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State.....**Mo.** (b) County.....**14 000**
 (c) City or town.....**St. Louis** **17**
 (If outside city or town limits, write "RURAL")
 (d) Street No.....**6341 Nottingham Ave.** **7**
 (If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

3. (a) PRINT FULL NAME

Leo P. Cronin

(b) If veteran, name war.....

(c) Social Security No.....

4. Sex.....**M.** 5. Color or race.....**W.** 6. (a) Single, widowed, married, divorced.....**M.**
 6. (b) Name of husband or wife.....**Margaret Cronin** 6. (c) Age of husband or wife if alive..... years
 7. Birth date of deceased.....**Dec. 15th., 1901**
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
40 2 7 hr. min.

9. Birthplace.....**St. Louis Mo. D**
 (City, town, or county) (State or foreign country)

10. Usual occupation.....**Salesman**

11. Industry or business

MOTHER FATHER { 12. Name.....**Timothy Cronin**
 13. Birthplace.....**Ireland**
 (City, town, or county) (State or foreign country)
 14. Maiden name.....**Winifred Rogers**
 15. Birthplace.....**Ireland**
 (City, town, or county) (State or foreign country)

16. (a) Informant.....**Mrs. Margaret Cronin**
 (b) Address.....**6341 Nottingham Ave.**

17. (a) **Burial** (b) Date thereof.....**2-25-1942**
 (Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director.....**Arthur J. Hennelly**
 (b) Address.....**3840 Lindell Blvd.**

19. (a) **FE** (b) **J. F. Deedee**
 (Data received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month.....**Feb.** day.....**22nd.** year.....**1942** hour.....**9** minute.....**8** M.

21. I hereby certify that I attended the deceased from.....**2-2-42** to.....**2-22** 19**42**
 that I last saw him alive on.....**2-21** 19**42**
 and that death occurred on the date and hour stated above.

Immediate cause of death.....**Subacute Bact. Endo -**
Carditis (Strept. coccus
viridans)

Due to.....**Jan 24-42**
57 Feb 22-42
 Due to.....
 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).....**no**
 (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.....**John Hammond** (M. D. or other) **M.D.**
 Address.....**6341 N Grand** Date signed.....**2/23/42**

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

No 5080

2-5

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 W H VanMatre
Licensed Embalmer No. 2825
P. O. Address 4340 Lafayette

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.