

Filed NOV 23 1943 y7

Primary Registration District No. 3016

1. PLACE OF DEATH:

(a) County Cole
 (b) City or town Jefferson City, Mo.
 (c) Name of hospital or institution: 325 Reav West Miller 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution ✓
 In this community 90 years
 years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cole
 (c) City or town Jefferson City, Mo.
 (d) Street No. 315 Reav West Miller
 (e) Citizen of foreign country? No
 If yes, name country 0

3. (a) PRINT FULL NAME MARY QUINLAN

3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced widowed
 6. (b) Name of husband or wife Michael Quinlan 6. (c) Age of husband or wife if alive 26 years
 7. Birth date of deceased May 1, 1850
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>93</u>	<u>6</u>	<u>16</u>	<u>-</u> hr. <u>-</u> min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER { 12. Name Unknown
 13. Birthplace Unknown (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 Stephen Quinlan
 (b) Address Jefferson City, Mo.

17. (a) Burial (b) Date thereof 11/20/43
 (Burial, cremation, or reinterment) (Month) (Day) (Year)
 (c) Place: burial or cremation St. Peter's Cemetery

18. (a) Signature of funeral director Lybusha Duke
 (b) Address Jefferson City, Mo.

19. (a) 11-19-43 (b) Harold Richter
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 17 year 1943 hour 9 minute 45 P.M.

21. I hereby certify that I attended the deceased from July 10 1943 to July 17 1943 and that death occurred on the date and hour stated above
 Immediate cause of death Cerebral hemorrhage
 Duration _____

Due to arterio-sclerosis

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

Major findings: Of operations g3a
 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 J. G. Bruce, M.D. (M. D. or other) _____
 Address Jefferson City, Mo. Date signed _____

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

6
5
4

X26350

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..... *Sybilster Sulle*

Licensed Embalmer No. *4321*

P. O. Address..... *Jefferson City, Mo.*

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.