

S. No. 2
 OM-5-43
 v. 5-17-39
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23029
 DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS
 FILED APR 20 1944

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. 12619

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3274

1. PLACE OF DEATH:
 (a) County.....
 (b) City or town..... St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Louis City Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 mo-8 days
(Specify whether "Life" or "Life")

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County 000
 (c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
 (d) Street No. 2518 So. 12 th. St.
(If rural, give location)
 (e) Citizen of foreign country? No. (Yes or No)
 If yes, name country 0

3. (a) PRINT FULL NAME Marie Theresa Calvin
 3. (b) If veteran, name war -
 3. (c) Social Security No. None

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month April day 5th
 year 1944 hour 8:35 minute P. M.
 21. I hereby certify that I attended the deceased from February 28th
1944 to April 5th 19 44
 that I last saw her alive on April 5th 19 44
 and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Dillard Calvin 6. (c) Age of husband or wife if alive 51 years
 7. Birth date of deceased January 31 1897
(Month) (Day) (Year)

Immediate cause of death Hemorrhage
Carcinoma of Lung
 Due to H
 Other conditions H
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day
47 2 4 hr. min.

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Home
 11. Industry or business.....
 12. Name Thomas Ryan
 13. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)
 14. Maiden name Mary Fitzmaurice
 15. Birthplace Unknown 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 Dillard Calvin
 (b) Address 2518 So. 12 th. St.
 17. (a) Burial (b) Date thereof 4/8/44
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation New SS Peter & Paul

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 Walter H. H. H. H. H.
 (b) Address 3634 Gravois Ave.
 19. (a) APR 7 1944 J. F. Breuch
(Date received local registrar) (Registrar's signature)

While at work?.....
(Specify type of place)
 (c) Means of injury.....
 23. Signature J. F. Breuch 1515 Lafayette (M. D. or other) 4/6/44
Date signed

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

Frank J. [Signature]

Licensed Embalmer No.

P. O. Address

*2645
[Signature]*

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.