

FILED MAR 16 1945

318

1003

2202

Registration District No.

Primary Registration District No.

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 6410 Wade Ave  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community 55 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Timothy Dwyer

3. (b) If veteran name war World War #1 3. (c) Social Security No. no

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years (Day) (Year)

7. Birth date of deceased May 1890  
(Month) (Day) (Year)

8. AGE: Years 54 Month 9 Days 29 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Public Service (Retired)

11. Industry or business \_\_\_\_\_

12. Name Timothy Dwyer

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

14. Maiden name Mrs. J. Sullivan

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

16. (a) Informant Mrs. John Corbett

(b) Address 6410 Wade

17. (a) Buried (b) Date thereof 3/9/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Culver Cemetery

18. (a) Signature of funeral director Jessie Howard

(b) Address 1619 S. Grand

19. (a) MAR 7 1945 (b) J. F. Brudak  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo County St. Louis  
(c) City or town St. Louis  
(If outside city or town limits, give "RURAL")  
(d) Street No. 6410 Wade  
(If rural, give location)  
(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 5<sup>th</sup>  
year 1945 hour 7 minute 30 P.M.

21. I hereby certify that I attended the deceased from Feb 10, 1945 to March 5, 1945  
that I last saw him alive on March 5, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis  
Due to gas poisoning in war 1918

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations none made

Of autopsy none made

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 Joseph Davie (M. D. or other) \_\_\_\_\_  
Address 312 N. 9th St Date signed 3-7-45

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

*Joe A. Howard*

Licensed Embalmer No. *4139*

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, fact should be so stated above.**