

FILED JUN 7 1945
Registration District No. 377

Primary Registration District No. 6076

Registrar's No. 1173

1. PLACE OF DEATH: *St. Louis*
 (a) County: *St. Louis*
 (b) City or town: *Forest Lawn*
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: *Mother of God Council Home*
 (If not a hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution: _____ (Specify whether
 In this community _____
 years, months or days)

3. (a) PRINT FULL NAME: *Mary Dudley*
 3. (b) If veteran, name war: _____
 3. (c) Social Security No. _____

4. Sex: *Female*
 5. Color: *Wh*
 6. (a) Single, widowed, married, divorced: *2 divorced*
 6. (b) Name of husband or wife: *Thomas*
 6. (c) Age of husband or wife if alive, years: *25*
 7. Birth date of deceased: *Jan 25 1880*
 (Month) (Day) (Year)

8. AGE: Years: *15* Months: *3* Days: *18*
 If less than one day: _____ hr. _____ min.

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

10. Usual occupation: _____

MOTHER FATHER
 11. Industry or business: _____
 12. Name: *Francis Placio*
 13. Birthplace: *Madrid Spain*
 (City, town, or county) (State or foreign country)
 14. Maiden name: *Mary*
 15. Birthplace: *Dublin Ireland*
 (City, town, or county) (State or foreign country)

16. (a) Informant: *Leo Placio*
 (b) Address: *7389 Northwood*

17. (a) *Burial* (b) Date thereof: *5-15-45*
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: *Galvargene*

18. (a) Signature of funeral director: *Chas F. Smart*
 (b) Address: *1275 Myron Blvd*

19. (a) *MAY 12 1945* (b) *E. G. H. Larson*
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State: *Mo* (b) County: *96*
 (c) City or town: *Brentwood* *9*
 (If outside city or town limits, write "RURAL")
 (d) Street No.: *8747 White Ave.*
 (If rural, give location)
 (e) Citizen of foreign country? *0* (Yes or No)
 If yes, name country: _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *May* day *13*
 year *1945* hour *10:00* minute *9* M.

21. I hereby certify that I attended the deceased from *Dec 30*, 19*43* to *May 13*, 19*45*
 that I last saw him alive on *May 13*, 19*45*
 and that death occurred on the date and hour stated above.

Immediate cause of death: *Left cerebral haemorrhage* Duration *2 yrs*
recurrent

Due to: *Hypertension* *2 yrs*

Due to: *83a*

Other conditions: *chronic myocarditis* *2 yrs*
 (Include pregnancy within 3 months of death)

Major findings: _____
 Of operations: _____
 Of autopsy: _____
 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: *Richard J. Cannon* (M.D. or other) *MD*
 Address: *5146 Old Louis Ave* Date signed: *5-15-45*

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

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

John Agorashi

Licensed Embalmer No. *3398*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. June
Registrar's No. 1123

Registration District No. 317

Primary Registration District No. 6076

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

In this community _____ years, months or days
 (Specify whether _____)

3. (a) PRINT FULL NAME Mary Dudley
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race w
 6. (a) Single, widowed, married, divorced wid
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Jan 25 (Month) (Day) (Year)

8. AGE: Years 65 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation None

11. Industry or business _____

MOTHER FATHER 12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (Date received local registrar) (b) E. G. McP... (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State _____ (b) County _____
 (c) City or town _____ (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Mar Day 3 Year 1945 Hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____
 Due to _____
 Due to _____
 Other conditions _____ (Include pregnancy within 3 months of death)

PHYSICIAN
 Major findings:
 Of operations _____
 Of autopsy _____
 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 _____ (M. D. or other) _____
 Address _____ Date signed _____

SUPPLEMENTARY

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

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