

S. No. 2
 FORM-5-43
 Rev. 5-17-39
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DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS
 THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **22302**
 Registrar's No. **5363**

FILED JUN 26 1946
 Registration District No. **318** Primary Registration District No. **1003**

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

1. PLACE OF DEATH:
 (a) County **St. Louis, Mo.**
 (b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **3966 North Market**
(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)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **000**
 (c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
 (d) Street No. **3966 North Market**
(If rural, give location)
 (e) Citizen of foreign country?.....
(Yes or No)
 If yes, name country.....

3. (a) PRINT FULL NAME **John Walsh**
 3. (b) If veteran, name war.....
 3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **W**
 6. (a) Single, widowed, married, divorced. **Married**
 6. (b) Name of husband or wife **Mary Smith**
 6. (c) Age of husband or wife if alive **79** years
 7. Birth date of deceased **Mar. 24 1865**
(Month) (Day) (Year)

8. AGE: Years **81** Months **2** Days **22**
 If less than one day
 hr. min.

9. Birthplace **Ireland** **4**
(City, town, or county) (State or foreign country)
10. Usual occupation **Retired Grocer**

11. Industry or business
12. Name **Owen Walsh**
13. Birthplace **Ireland** **4**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace..... **4**
(City, town, or county) (State or foreign country)

16. (a) Informant **Loretta Hanna**
(b) Address **3966 North Market**

17. (a) Burial **Calvary Cemetery** **(b) Date thereof** **June 19, 46**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Bromschwig Und. Co.**

18. (a) Signature of funeral director.....
(b) Address **4746 West Florissant**

19. (a) **JUN 17 1946** **J. F. Budack**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **June** day **16**
 year **1946** hour **6** minute **A.M.**
21. I hereby certify that I attended the deceased from **June 1**
1946 to **June 16** **1946**
 that I last saw him alive on **June 15** **1946**
 and that death occurred on the date and hour stated above.

Immediate cause of death.....
Cerebral Hemorrhage
 Due to **Arteriosclerosis**
 Due to.....
 Other conditions.....
(Include pregnancy within 3 months of death)

PHYSICIAN
 Major findings:
 Of operations.....
 Of autopsy.....

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 **B. C. Emerson** (M. D. or other).....
Address **6022 Maple** **Date signed** **June 17**

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..... *R. W. Wilkins*
Licensed Embalmer No..... *3575*
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.