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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED MAR 11 1947

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

6834  
State File No. \_\_\_\_\_  
Registrar's No. 1905

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH:  
(a) County St. Louis, Mo.  
(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  
Max G. Starkloff Memorial  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 4. DAYS  
years, months or days

3. (a) PRINT FULL NAME THOMAS QUAYLE  
3. (b) If veteran, name war None  
3. (c) Social Security No. None

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  
7. Birth date of deceased Jan 8 1874  
(Month) (Day) (Year)

8. AGE: Years 73 Months 1 Days 13  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Washington Ind. 1  
(City, town, or county) (State or foreign country)

10. Usual occupation Chef

11. Industry or business Restaurant

12. Name Robert Quayle

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

14. Maiden name Eden Quilley

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

16. (a) Informant Joseph Quayle

(b) Address Cashville Ill

17. (a) Burial (b) Date thereof 2-23-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation E. ST. LOUIS

18. (a) Signature of funeral director Robin Funeral Home

(b) Address East St. Louis Ill.

19. (a) FEB 25 1947 (b) J. F. Bredek  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State MO (b) County ST LOUIS  
(c) City or town ST LOUIS  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5 16 9 ST  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month February day 21  
year 1947 hour 1:26 minute P M.  
21. I hereby certify that I attended the deceased from February 17, 1947, to February 21, 1947  
that I last saw him alive on February 21, 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Vasc. Accident Duration 4 days  
Due to \_\_\_\_\_  
Due to Cerebral Arterio-sclerosis 10 yrs.  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
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 Joe W. J. Harkin (M.D. or other) \_\_\_\_\_  
Address 2515 Lafayette Avenue Date signed 2/21/47

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

1905

**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 Me

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed Frank Praloff

Licensed Embalmer No. 4356

P. O. Address 424 N. 8 St. E. St. Louis

**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.**