

FILED JUL 12 1947

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **22139**

Registration District No. **318**

Primary Registration District No. **1002**

Registrar's No. **6426**

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: Christian Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 17 days  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County 050  
(c) City or town St. Louis 17  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1419 Angelica St. 9  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Malley Colley  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. None

20. DATE OF DEATH: Month July day 5th  
year 1947 hour 2.50 minute \_\_\_\_\_ P. M.

4. Sex Male 5. Color or race W  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Anna Colley 6. (c) Age of husband or wife if alive 55 years  
7. Birth date of deceased Dec. 31st, 1888  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 6-18 1947 to 7-5 1947  
that I last saw him alive on 7-5 and that death occurred on the date and hour stated above.  
Immediate cause of death Cerebral hemorrhage

8. AGE: Years 58 Months 6 Days 4 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

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

Other conditions Abdominal ecchymosis  
(Include pregnancy within 3 months of death)

10. Usual occupation Tavern Owner

11. Industry or business Liquor

12. Name Colley  
13. Birthplace Unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Emily Polite  
15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

Major findings: Incarcerated by sliding hernia  
Of autopsy: Abdominal ecchymosis, retroperitoneal

16. (a) Informant Anna Colley  
(b) Address 1419 Angelica ST.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_

17. (a) Burial (b) Date thereof 7-8-47  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation New Bethlehem Cem.

(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 Suedmeyer & Sons  
(b) Address 39-4 n. 20th. St.

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_

19. (a) JUL 7 (b) J. F. Brodeur  
(Date received local registrar) (Registrar's signature)

23. Signature J. E. T. Joflat (M. D. or other) MD  
Address 4222 N. Grand Date signed 7-7-47

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

MOTHER / FATHER

Duration 3 weeks

PHYSICIAN

Underline the cause to which death should be charged statistically.

**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.....

A. G. Smithers

Licensed Embalmer No. 3916

P. O. Address..... 3934 N. 70

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to sign the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**