

No. 2  
-1/47  
5-17-39

Office of Vital Statistics  
**FILED AUG 16 1947**

Registration District No. 31

Primary Registration District No. 6076

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Wellston  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution St. Vincents Sanatarium  
(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 MO (b) County \_\_\_\_\_

(c) City or town Rural  
(If outside city or town limits, write "RURAL")

(d) Street No. 7300 St. Charles Rd  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Margaret G. Crotty

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex F / race W

5. Color of hair W

6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased August 25, 1872  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>74</u>	<u>11</u>	<u>6</u>	_____ hr. _____ min.

9. Birthplace Ireland (City, town, or county) (State or foreign country) 4

10. Usual occupation Housewife

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

12. Name Michael Crotty

13. Birthplace Ireland (State or foreign country) 7

14. Maiden name Margaret Walsh (State or foreign country)

15. Birthplace Ireland (City, town, or county) (State or foreign country) 4

16. (a) Informant Mary Crotty

(b) Address 5149 Cates Ave.

17. (a) Burial, cremation, or removal burial (b) Date thereof 8-2-1947  
(Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Harrigan & Sheahan

(b) Address 4415 Washington Bl.

19. (a) 8-1-47 (Date received local registrar)

(b) Cecilia J. Sharp (Registrar's signature) MS Address \_\_\_\_\_ Date signed \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 30 year 1947 hour 9 minute 10 P.M.

21. I hereby certify that I attended the deceased from Nov 24 1943 to July 30 1947; that I last saw her alive on July 30 and that death occurred on the date and hour stated above.

Immediate cause of death Broncho pneumonia 2 days

Psychosis with senility 5 yrs

fractured anterior femur 2 days

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

Major findings: Of operations 186a

Of autopsy 11

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_ 96

(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? \_\_\_\_\_ (Specify type of place)

While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

Signature W B J Han (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

MOTHER FATHER



MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County St Louis  
(b) City or town Wellston  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St Vincents Sanatarium  
(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)

3. (a) PRINT FULL NAME Margaret G Crotty  
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 S  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ year  
7. Birth date of deceased 8/25/72  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one year  
74 11 6 min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business Housewife

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_ (State or foreign country)

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

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

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County \_\_\_\_\_  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. 7300 St Charles Rock Rd  
(If rural, give location)  
(e) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH Month July day 30  
year 1947 hour 9 minute 10 P. M.

21. I hereby certify that I attended the deceased from Nov. 24 30  
1943 to July 30 1947;  
that last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia Duration \_\_\_\_\_

Psychosis with senility and cerebral arteriosclerosis.  
Due to \_\_\_\_\_

Fracture of right femur.  
Due to \_\_\_\_\_

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) Accident Fall

(b) Date of occurrence July 28, 1947

(c) Where did injury occur? St. Vincent's Sanitarium  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
St. Vincent's Sanitarium

While at work? No (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature W.S. Patten (M. D. or other) \_\_\_\_\_  
Address St. Vincent's San. Date signed 8-4-47

7300 St. Chas. Rk. Rd., St. Louis (14)

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

SUPPLEMENTARY

S-29873