No. 2
-12-45
-17-39
X47070

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 29 1947

Registration District No. 312

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6676

36576

State File No.

Registrar's No. 2213

1. PLACE OF DEATH:

(a) County St. Louis County

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

(c) Name of hospital or institution: 9402 Liberty Ave
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community Since Birth
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Odo

(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 1510 N 10th. St. 9
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME MARY DINAN

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

5. Color or race white

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

6. (b) Name of husband or wife Robert Dinan- deceased

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

7. Birth date of deceased Feb. (Month) 4th (Day) 1865 (Year)

8. AGE: Years 82 Months 8 Days 12 If less than one day hr. min.

9. Birthplace St. Louis Mo. (City, town, or county) 0 (State or foreign country)

10. Usual occupation housework

11. Industry or business

FATHER
12. Name Patrick Shaffray
13. Birthplace Ireland (City, town, or county) 4 (State or foreign country)

MOTHER
14. Maiden name Julia Carlain
15. Birthplace Ireland (City, town, or county) 4 (State or foreign country)

16. (a) Informant Mrs. Julia E Oliver- daughter

(b) Address 9402 Liberty Ave. Overland Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 20th 847 (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Hy. Leidner Und Co

(b) Address 2223 St. Louis Mo.

19. (a) 10-22-47 (Date received local registrar) (b) Paula J Shaffray MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 16 year 47 hour minute M.

21. I hereby certify that I attended the deceased from October 14, 1947 to October 16, 1947 that I last saw her alive on October 16, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Congestive heart failure	Weeks
Due to Cardiac Hypertrophy	?
Due to 95	
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? (Specify type of place)

While at work? (e) Means of injury 0

23. Signature H. H. Feller (M. D. or other) M.D.

Address 2803 N. Grand Date signed 10-17-47

(Licensed Embalmer's Statement on Reverse Side)

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 P. [illegible]

Licensed Embalmer No. [illegible]

P. O. Address [illegible]

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.