

FILED OCT 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35635

State File No. 8784

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY	
b. CITY OR TOWN St. Louis (7)		c. CITY OR TOWN St. Louis (9)	
c. LENGTH OF STAY (in this place) 60 yrs.		d. STREET ADDRESS (If rural, give location) 1319 Laclede Ave.	
d. FULL NAME OF HOSPITAL OR INSTITUTION De Paul Hospital		4. DATE OF DEATH (Month) (Day) (Year) Oct. 11, 1949	
3. NAME OF DECEASED (Type or Print) a. (First) Michael Syron		b. (Middle)	
c. (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
5. SEX M. (D)	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married /	8. DATE OF BIRTH Unknown 1871
9. AGE (in years last birthday) 78	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Stone Mason	10b. KIND OF BUSINESS OR INDUSTRY Stone Mason	11. BIRTHPLACE (State or foreign country) Ireland (4)	12. CITIZEN OF WHAT COUNTRY?
13a. FATHER'S NAME Thomas Syron		13b. MOTHER'S MAIDEN NAME Bridget Mayock	
14. NAME OF HUSBAND OR WIFE Mary Syron			

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 495-11-9537	17. INFORMANT'S SIGNATURE OR NAME Mrs. Mary Syron	ADDRESS 1319 Laclede Ave.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Corporation duodenal ulcer		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Unknown DUE TO (c) Arteriosclerosis		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		2 yrs	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION Not operated upon	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 99
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4500

22. I hereby certify that I attended the deceased from Oct 9, 1945, to Oct 11, 1945, that I last saw the deceased alive on Oct 11, 1945, and that death occurred at 11:15 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) J. B. Fusaler M.D.	23b. ADDRESS 1117 N. Grand Blvd	23c. DATE SIGNED Oct 11/45
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10-11-49	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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DATE REC'D BY LOCAL REG. OCT 13 1949	REGISTRAR'S SIGNATURE J. B. Fusaler	25. FUNERAL DIRECTOR'S SIGNATURE Arthur J. Donnelly	ADDRESS 3840 Lindell Blvd
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(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 _____

working under my personal supervision.

Student
Student Embalmer

Student Embalmer No. _____

Signed *Thomas R. Fenwick*

Licensed Embalmer No. *3793*

P. O. Address *3840 Lenox*

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.