

FILED JAN 16 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3438

State File No.
Registrar's No. **0063**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. 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 (If outside corporate limits, write RURAL and give township) OR TOWN **St. Louis, Mo.** c. LENGTH OF STAY (In this place) _____

c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN **St. Louis, Mo.** d. FULL NAME OF HOSPITAL OR INSTITUTION **4219 Westminister.** e. STREET ADDRESS (If rural, give location) **4219 Westminister. 0.**

3. NAME OF DECEASED (Type or Print)
a. (First) **Mary** b. (Middle) **Jane** c. (Last) **Walsh.**

4. DATE OF DEATH (Month) (Day) (Year)
Jan. 2 1952

5. SEX **Female** 6. COLOR OR RACE **White** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) **Never married** 8. DATE OF BIRTH **Apr. 29, 1873.** 9. AGE (In years last birthday) **78** IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 4 HRS. Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Housework** 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (State or foreign country) **St. Louis, Mo.** 12. CITIZEN OF WHAT COUNTRY? **U**

13a. FATHER'S NAME **Walter Walsh.** 13b. MOTHER'S MAIDEN NAME **Mary Jane O'Brien** 14. NAME OF HUSBAND OR WIFE _____

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, state war or dates of service) **None** 16. SOCIAL SECURITY NO. _____ 17. INFORMANT'S SIGNATURE OR NAME **Margaret Heatherston** ADDRESS **4219 Westminister?**

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
Acute Broncho Pneumonia
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ ANTECEDENT CAUSES _____ DUE TO (b) _____ DUE TO (c) _____
II. OTHER SIGNIFICANT CONDITIONS **Chronic Myocarditis.** INTERVAL BETWEEN ONSET AND DEATH **3 days**

19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION _____ 20. AUTOPSY? YES NO

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) _____

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____ 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? **H91X**

22. I hereby certify that I attended the deceased from **1-1-**, 1952 to **1-2-**, 1952 that I last saw the deceased alive on **1-2-**, 1952, and that death occurred at **11:00 A.m.**, from the causes and on the date stated above.

23a. SIGNATURE **J. J. Quinn** (Degree or title) _____ 23b. ADDRESS **1389 Union Blvd** 23c. DATE SIGNED **1-2-52**

24a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 24b. DATE **Jan. 5, 1952.** 24c. NAME OF CEMETERY OR CREMATORY **Calvary Cemetery** 24d. LOCATION (City, town, or county) (State) **St. Louis, Mo.**

DATE REC'D BY LOCAL REG. **JAN 4 1952** REGISTRAR'S SIGNATURE **J. Earl Smith M.D.** 25. FUNERAL DIRECTOR'S SIGNATURE **J. J. Quinn** ADDRESS **1389 Union Blvd**

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

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *Ben C. Hoffman* _____

Licensed Embalmer No. *4366* _____

P. O. Address *St Louis Mo* _____

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.