

THE DIVISION OF HEALTH OF MASSACHUSETTS
STANDARD CERTIFICATE OF DEATH

19361

FILED JUN 10 1953

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1003

State File No.

5211

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

1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri c. LENGTH OF STAY (in this place) 1 MONTH d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY _____ c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST LOUIS d. STREET ADDRESS (If rural, give location) 12 716 BELT AVE	
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3. NAME OF DECEASED (Type or Print) WINIFRED FALVEY			4. DATE OF DEATH (Month) (Day) (Year) MAY 29, 1953					
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED 2	8. DATE OF BIRTH JULY 29, 1895	9. AGE (in years last birthday) 57	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SCHOOL TEACHER	10b. KIND OF BUSINESS OR INDUSTRY GRADE SCHOOL	11. BIRTHPLACE (City and State or Foreign Country) WILLMANTIC CONN.	12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME JOHN P. CHROWLEY	13b. MOTHER'S MAIDEN NAME HANNAH E CASEY	14. NAME OF HUSBAND OR WIFE PATRICK P. FALVEY
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. 034-20-6710	17. INFORMANT'S SIGNATURE OR NAME ADDRESS ROSE MARIE FALVEY, 716 BELT AVE

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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Post operative Splenectomy ANTECEDENT CAUSES Spleno-megaly of myeloid leukemia DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH _____
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____ 2041

22. I hereby certify that I attended the deceased from 4-23-53, 1953, to 5-29-53, 1953, that I last saw the deceased alive on 5-29-53, 1953, and that death occurred at 12:35Pm., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Robert Thomas MD	23b. ADDRESS 1515 Lafayette Avenue	23c. DATE SIGNED 5-25-53	
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	24b. DATE MAY 25, 1953	24c. NAME OF CEMETERY OR CREMATORY ST MICHAEL	24d. LOCATION (City, town, or county) (State) SPRINGFIELD MASS.

DATE REC'D BY LOCAL REG. MAY 25 1953	REGISTRAR'S SIGNATURE J. C. Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Cullen Kelly 4386 LINDELL BLVD
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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 James A. Linnell

Licensed Embalmer No. 4142

P. O. Address St. Louis

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.