

FILED DEC 17 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

42722

State File No. ....

11075

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>11075</b>			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MO.</b> b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis, Mo.</b>		c. LENGTH OF STAY (in this place) <b>14 Days</b>		c. CITY OR TOWN <b>St. Louis, Mo.</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Christian Hospital.</b>				e. STREET ADDRESS (If rural, give location) <b>20790</b> <b>7 6127 Sherry Ave.</b>					
3. NAME OF DECEASED (Type or Print) <b>Thomas F. Quinn.</b>			a. (First)		b. (Middle)		c. (Last)		
4. DATE OF DEATH		(Month) (Day) (Year)		<b>12 3 54</b>					
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>Aug. 15, 1891.</b>			
9. AGE (In years last birthday) <b>63</b>		IF UNDER 1 YEAR Months		IF UNDER 1 YEAR Days		IF UNDER 1 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pipefitter</b>			10b. KIND OF BUSINESS OR INDUSTRY _____			11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Mo.</b>			
12. CITIZEN OF WHAT COUNTRY? _____			13a. FATHER'S NAME <b>Joseph J. Quinn.</b>		13b. MOTHER'S MAIDEN NAME <b>Mary E. McGrath.</b>		14. NAME OF HUSBAND OR WIFE <b>Marcelle Quinn.</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No None</b>			16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <b>Marcelle Quinn</b>			ADDRESS <b>6127 Sherry Ave.</b>	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral hemorrhage</b>						MEDICAL CERTIFICATION	
		ANTECEDENT CAUSES						INTERVAL BETWEEN ONSET AND DEATH	
		*Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Right hemiplegia</b>							
		DUE TO (c) _____							
		II. OTHER SIGNIFICANT CONDITIONS							
		Conditions contributing to the death but not related to the disease or condition causing death. <b>arteriosclerosis</b>							
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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>331X</b>					
22. I hereby certify that I attended the deceased from <b>11-28, 1954 to 12-3, 1954</b> that I last saw the deceased alive on <b>12-3, 1954</b> and that death occurred at <b>1:50 P.M.</b> , from the causes and on the date stated above.									
23a. SIGNATURE <b>John J. Bernwald M.D.</b>				(Degree or title)		23b. ADDRESS <b>3409 N. Union</b>		23c. DATE SIGNED <b>12/4/54</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>Dec. 6, 1954</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Cakvary</b>		24d. LOCATION (City, town, or county) <b>St. Louis, Mo.</b> (State) _____			
DATE REC'D BY LOCAL REG. <b>DEC 6 1954</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith MO</b>			25. FUNERAL DIRECTOR'S SIGNATURE <b>J. J. Quinn</b> ADDRESS <b>1389 Union</b>				

(Licensed Embalmer's Statement on Reverse Side)

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

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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.....  
Signature of Student Embalmer

Signed *Donald O. Y. Adams*.....

Licensed Embalmer No. *391*.....

P. O. Address.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.