No. 300
10.48

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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2494

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 0840

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

1. PLACE OF DEATH
a. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (in this place)

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5720 Cates Ave. / 2059

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis

d. STREET ADDRESS (If rural, give location): 5720 Cates

3. NAME OF DECEASED (Type or Print)
a. (First): Alice
b. (Middle): Cecelia
c. (Last): Dwyer

4. DATE OF DEATH (Month) (Day) (Year): 1-27-55

5. SEX: Female /
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Nov. 20, 1874
9. AGE (In years last birthday): 80 — IF UNDER 1 YEAR: Months 2, Days 7 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and State or Foreign Country): Carlinville, Ill. /
12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME: Patrick Moran
13b. MOTHER'S MAIDEN NAME: Alice Egan
14. NAME OF HUSBAND OR WIFE: Patrick

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: ——
17. INFORMANT'S SIGNATURE OR NAME ADDRESS: Paul A. Dwyer 5720 Cates

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

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral accident

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cardio Vascular disease
DUE TO (c) Senility

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. ✓

INTERVAL BETWEEN ONSET AND DEATH: 3 mo

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) m. ✓
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? ✓ 4221

22. *I hereby certify that I attended the deceased from* 1/9, 1944, *to* 1/27, 1955, *that I last saw the deceased alive on* 1/27, 1955, *and that death occurred at* 9:00P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Bruce O'Reilly MD
23b. ADDRESS: 730 Hodiamont ave
23c. DATE SIGNED: 1/28/55

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 1/31/55
24c. NAME OF CEMETERY OR CREMATORY
24d. LOCATION (City, town, or county) (State): Litchfield, Ill.

DATE REC'D BY LOCAL REG.: JAN 29 1955
REGISTRAR'S SIGNATURE: J. Carl Smith - MD
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Chas. F. Stuart 1225 Union

acm

(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.....

..... Student Embalmer No. .....,

working under my personal supervision.

Student .....
Student Embalmer.

Signed Robert M. Murray

Licensed Embalmer No. 3749

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.