

XC 1992563
REG. 9397 SL 994
FILED AUG 2 - 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24238
5816

State File No.

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 Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN 915 N. Grand, St. Louis, Mo.)	c. LENGTH OF STAY (In this place) 9 Days	c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Veterans Administration Hospital		e. STREET ADDRESS (If rural, give location) 5626a Easton Avenue	

3. NAME OF DECEASED (Type or Print)	a. (First) Thomas	b. (Middle) M.	c. (Last) Quinlivan	4. DATE OF DEATH (Month) (Day) (Year) 7-4-1955
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWER, DIVORCED (Specify) Married	8. DATE OF BIRTH 10-30-1887	9. AGE (In years last birthday) 67	IF UNDER 1 YEAR Months 93	IF UNDER 12 HRS. Days 4 Hours 4 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tile Setter	10b. KIND OF BUSINESS OR INDUSTRY Construction	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME John Quinlivan	13b. MOTHER'S MAIDEN NAME Margaret Hayes	14. NAME OF HUSBAND OR WIFE Rose Quinlivan
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give year or dates of service) WWI	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME VA Hospital Records, St. Louis, Mo.	ADDRESS
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 years
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CARCINOMA OF BLADDER WITH GENERALIZED METASTASES		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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. PYELONEPHRITIS		Undetermined	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)
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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? 181X
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22. I hereby certify that I attended the deceased from **6-25**, 19**55**, to **7-4**, 19**55**, that he was ~~deceased~~ **deceased** and that death occurred at **8:00 Pm.**, from the causes and on the date stated above.

23a. SIGNATURE Wesley Westphaelinger (Degree or title) M.D.	23b. ADDRESS VAH, ST. LOUIS, MO.	23c. DATE SIGNED 7-4-55
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24a. DATE OF CREMATION, REMOVAL (Specify) Removal	24b. DATE 7/8/55	24c. NAME OF CEMETERY OR CREMATORY Memorial Park	24d. LOCATION (City, town, or county) (State) St. Louis, Co.
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DATE REC'D BY LOCAL REG. JUL 6 1955	REGISTRAR'S SIGNATURE J. Earl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Edward J. ...	ADDRESS 5611 S. Grand
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S.P. (Licensed Embalmer's Statement on Reverse Side)

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.....
Signature of Student Embalmer

Signed..... *Bew E. Hoffmann*

Licensed Embalmer No. *436*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.