

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

NOV 13 1934

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

37696

1. PLACE OF DEATH

County Registration District No. **791**
Township Primary Registration District No. **1003**
City **St. Louis Mo** (No. **4467**) **Magnolia Av.** St. **17** Ward.

File No.
Registered No. **10144**
St. Ward

2. FULL NAME

Mary C. McArdie
(a) Residence, No. **4467 Magnolia** St., **17** Ward.
(Usual place of abode)
Length of residence in city or town where death occurred **43 yrs. 5 mos.** - ds. How long in U. S., if of foreign birth? **43 yrs. 5 mos.** - ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female	4. COLOR OR RACE White	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married			
5A. IF MARRIED, WIDOWED, OR DIVORCED (OR) WIFE OF David J. McArdie					
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 29, 1865					
7. AGE	YEARS 69	MONTH 8	DAYS 24	If LESS than 1 day, hrs. or min.	
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. At Home				
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.				
	10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation		
MOTHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) England				
	FATHER	13. NAME James Swann			
		14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) England			
		15. MAIDEN NAME Eunice Grant			
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Scotland					
17. INFORMANT (ADDRESS) Mrs. Geo. N. Pring 4467 Magnolia Av.					
18. BURIAL, CREMATION, OR REMOVAL PLACE DeKalb Cem. Oct. 19, 1934					
19. UNDERTAKER (ADDRESS) Berglund and Co 366 Westinghouse Bldg					
20. FILED Nov 13 1934 Joe J. Brebeck Registrar.					

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Oct 16, 1934**

22. I HEREBY CERTIFY, That I attended deceased from **Feb. 27, 1934**, to **Oct 16, 1934**
I last saw h. **av** alive on **Oct 15, 1934** Death is said to have occurred on the date stated above, at **11:30 a.m.**
The principal cause of death and related causes of importance were as follows:
93C
Chronic Myocarditis **Feb 27/34**
Other contributory causes of importance: **none**
Name of operation Date of
What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury 19.....
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? **No**
If so, specify
(Signed) **J. P. Nemerech Jr**, M. D.
(Address) **6200 Columbia Ave**

