

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

34120
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No. 791
(b) Township St. Louis..... Primary Registration District No. 1003
(c) City..... (d) Street No. City Hospital No. 1 Registered No. 9106
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. Mary Mc Coy
4397 Forest Park St. 19
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX female
4. COLOR OR RACE white
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED single

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10/18/38

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

22. I HEREBY CERTIFY That I attended deceased from 10/6/38 to 10/18/38, 19...
I last saw her alive on 10/18/38, 19... Death is said to have occurred on the date stated above, at 2:36 p.m.
The principal cause of death and related causes of importance were as follows:

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 17, 1879
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 58 10 1

Chronic Myocarditis
Arterio sclerosis
Pulmonary Embolism
Auricular Thrombosis
Other contributory causes of importance: Thrombosis of left subclavian artery
Date of onset

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. nil
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis, Missouri

FATHER 13. NAME Michael Mc Coy
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis, Missouri

MOTHER 15. MAIDEN NAME Margaret Brennan.
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

17. INFORMANT Hosp. Info M. Kent (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE Calvary DATE Oct. 20, 38

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Arthur J. J. Donnelly 3840 Lindell Blvd.

20. FILED OCT 19 1938 J. F. Bredeck Local Registrar.

Name of operation..... Date of.....
What test confirmed diagnosis?..... Was there an autopsy? yes

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?.....
If so, specify M. F. Hall, M. D. (Signed) City Hospital No. 1 (Address)

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

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

Registered Apprentice No., working under my personal supervision.

Signed

Stanley Marchese

Licensed Embalmer No.

2868

P. O. Address

3840 Lindell

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, above space should be left blank.