

RECD JUN 12 1939

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

791  
1008  
17011  
Do not use this space.  
4575

1. PLACE OF DEATH

(a) County..... 2 Registration District No.....  
(b) Township..... Primary Registration District No.....  
(c) City or ST. LOUIS (d) Street No. 3669 CASTLEMAN AV. St. (If death occurred in Hospital or Institution, write its name instead of street and number)  
(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

253 THOMAS J. McENTEE  
(a) Residence, No. 3669 CASTLEMAN AV. St. 17 (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX MALE 4. COLOR OR RACE WHITE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) MARRIED  
5A. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF (OR) WIFE OF JULIAM McENTEE  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) NOV 27-1896

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
42 5 22

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. ELECTRICIAN  
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 MO

FATHER 13. NAME THOMAS McENTEE

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) IRELAND

MOTHER 15. MAIDEN NAME MARGARET FARRINGTON

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) IRELAND

17. INFORMANT (ADDRESS) JULIA McENTEE 3669 CASTLEMAN AV.

18. BURIAL, CREMATION, OR REMOVAL PLACE CALVARY CEM. DATE MAY 20 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) E. J. Schurr 3125 Lafayette av.

20. FILED MAY 19 1939 19... J. B. Budack Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) MAY 18 1939

22. I HEREBY CERTIFY, That I attended deceased from Jan. 1934 to May 18, 1939  
I last saw him alive on May 18, 1939. Death is said to have occurred on the date stated above, at 6:15 AM.  
The principal cause of death and related causes of importance were as follows:

Acute Dilatation of Heart  
Chronic Myocarditis 1934  
Date of onset 5-18-39

Other contributory causes of importance:  
Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? NO

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) John A. Grant, M. D. (Address) 3902 Russell

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

1 X16003

**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.....

*Joseph Vollmer*

Licensed Embalmer No. *21014*

P. O. Address *3125 Lafayette ave*

**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.**