

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.

Registration District No.

1003

Primary Registration District No.

Registrar's No.

6156

1. PLACE OF DEATH:

(a) County _____
 (b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
De Paul Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 days
(Specify whether _____)
 In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis
 (c) City or town Maplewood
(If outside city or town limits, write "RURAL")
 (d) Street No. 3145 Walter Ave.
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 11th
 year 1939 hour 2:15 minute A.M. M.
 21. I hereby certify that I attended the deceased from July 5, 1939, to July 11, 1939,
 that I last saw him alive on July 10, 1939,
 and that death occurred on the date and hour stated above.

Immediate cause of death
Cancer of penis
Metastatic cancer of
stomach
 Duration
1+ yrs
3-4 mths

Due to _____
 Due to _____
 Other conditions
(Include pregnancy within 3 months of death)
51

Major findings:
 Of operations _____
 Of autopsy _____
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
 (c) Means of injury _____
 23. Signature C. M. Charles (M.D. or other) MD
 Address 632 Metropolitan Bldg Date signed 7-12-39

3. (a) PRINT FULL NAME Frank J. McDermott Sr. 236

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Aurelia McDermott 6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased July 26 1864
(Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
<u>74</u>	<u>11</u>	<u>15</u>	_____ hr. _____ min.

9. Birthplace Ruma Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer retired

11. Industry or business _____

12. Name James McDermott

13. Birthplace Ireland
(City, town, or county) (State or foreign country)

14. Maiden name Rose McCann

15. Birthplace Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Aurelia McDermott

(b) Address 3145 Walter Ave.

17. (a) Burial (b) Date thereof 7-13-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Kriegshauser Mortuaries

(b) Address 4228 So. Kingshighway

19. (a) JUL 12 1939 (b) J. B. Bredbeck
(Date received local registrar) (Signature of registrar)

Dr. C.M. Charles
Metrop. Bldg.

11-1 Wed
In 5022

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 Edurn M. Bernatt

Licensed Embalmer No. 3024

P. O. Address.....

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.