

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REC'D SEP 7 1939

Registration District No. 184

Primary Registration District No. 106

Registrar's No. 1567

1. PLACE OF DEATH: 3

(a) County St. Louis

(b) City or town Kirkwood, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Agnes Home.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 1/2 Years.
(Specify whether years, months or days)

In this community 5 Years.
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED: 1

(a) State Mo. (b) County _____

(c) City or town Kirkwood.
(If outside city or town limits, write "RURAL")

(d) Street No. St. Agnes Home.
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Catherine Le Gare. 260

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced 1

6. (b) Name of husband or wife Arthur Le Gare. 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased January 19 1864.
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 2 year 1939 hour 11 minute 15 A. M.

21. I hereby certify that I attended the deceased from 8/11, 1939, to 9/2, 1939; that I last saw her alive on 9/1, 1939; and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

75 7 13 hr. min.

Immediate cause of death Pneumonia Hypostatic Duration 48 hrs

Due to Ch Myocarditis

Due to _____

9. Birthplace New York.
(City, town, or county) (State or foreign country)

10. Usual occupation At Home.

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

Major findings: 93C

Of operations _____

Of autopsy _____

11. Industry or business _____

MOTHER FATHER { 12. Name George Hughes.

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

14. Maiden name Catherine Mallia.

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

PHYSICIAN _____

Underline the cause to which death should be charged statistically

16. (a) Informant's own signature Arthur Le Gare

(b) Address 4540 N Kingshighway

17. (a) Burial (b) Date thereof Sept 15-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery.

18. (a) Signature of funeral director Arthur J. Donnell

(b) Address 3840 Lindbergh Blvd

19. (a) SEP 4 1939 (b) DR. Meyer
(Date received local registrar) (Registrar's signature)

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)

(a) Means of injury _____

23. Signature Jane G. Pelleran (M. D. or other)

Address 2845 Union Pl Date signed 9/3/39

2864
16-91
W. H. ...

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

Alfred J. Boedeker

Licensed Embalmer No. *2663*

P. O. Address *4204 Prairie*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

30177

Do not use this space.

1. PLACE OF DEATH

(a) County St Louis Registration District No. 784
 (b) Township _____ Primary Registration District No. 126
 (c) City Herkwood (d) Street No. _____ 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. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

Registered No. 1567

2. PRINT FULL NAME Catherine Le Gare

(a) Residence, No. _____ St. (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 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS 75- MONTHS 7 DAYS 13 IF LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION 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. _____
 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)

FATHER 13. NAME _____

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

MOTHER 15. MAIDEN NAME _____

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

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED 9-4 1939 R. Meyer Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-2 1939

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance:

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? _____
 If so, specify _____ (Signed) Jas. A. Sullivan, M. D.
 (Address) 2864 N. Union Blvd.

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

