

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEC 12 1939

Registration District No. **784**

Primary Registration District No. **111**

Registrar's No. **2136**

**1. PLACE OF DEATH:**  
 (a) County \_\_\_\_\_  
 (b) City or town **Richmond Heights**  
 (c) Name of hospital or institution: **St. Mary's Hospital**  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **30 days**  
 In this community \_\_\_\_\_ years, months or days

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State **Missouri** (b) County \_\_\_\_\_  
 (c) City or town **St. Louis**  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. **3851 DeTonty Street**  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

**3. (a) PRINT FULL NAME** **Michael J. McNamara 253**  
**3. (b) If veteran, name war** **None** **3. (c) Social Security No.** \_\_\_\_\_

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month **December** day **4th**  
 year **1939** hour **7** minute **15** P. M.

**4. Sex** **Male** **5. Color or race** **White**  
**6. (a) Single, widowed, married, divorced** **Married**  
**6. (b) Name of husband or wife** **Aurelia McNamara** **6. (c) Age of husband or wife if alive** **59** years  
**7. Birth date of deceased** **February 10, 1881**  
 (Month) (Day) (Year)

**21. I hereby certify that I attended the deceased from** \_\_\_\_\_  
 to \_\_\_\_\_, 1939  
 that I last saw him alive on \_\_\_\_\_, 1939  
 and that death occurred on the date and hour stated above.

**8. AGE:** Years **58** Months **9** Days **24**  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

**Immediate cause of death**  
**Respiratory Failure**  
**Due to** **Myocardial Infarction**  
**Due to** **Brain Tumor**  
 Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
 Major findings: **Brain Tumor**  
 Of operations: \_\_\_\_\_  
 Of autopsy: **Brain Tumor**

**9. Birthplace** **St. Louis Missouri**  
 (City, town, or county) (State or foreign country)

**10. Usual occupation** **Letter Carrier**  
**11. Industry or business** **U. S. Post Office**

**MOTHER FATHER**  
**12. Name** **John McNamara**  
**18. Birthplace** **Mayo Ireland**  
 (City, town, or county) (State or foreign country)  
**14. Maiden name** **Sarah Prendergast**  
**15. Birthplace** **Mayo Ireland**  
 (City, town, or county) (State or foreign country)

**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)  
 (e) Means of injury \_\_\_\_\_

**16. (a) Informant's own signature** **Mrs Aurelia M. McNamara**  
**(b) Address** **3851 DeTonty Street**

**17. (a) Burial** **(b) Date thereof** **Dec. 7, 1939**  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
**(c) Place: burial or cremation** **Calvary Cemetery**

**18. (a) Signature of funeral director** **W. J. Robert**  
**(b) Address** **1905 So. Grand Blvd.**  
**19. (a) DEC 6 1939** **(b) R. R. Meyer**  
 (Date received local registrar) (Registrar's signature)

**23. Signature** \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
**Address** **University City, Mo.** **Date signed** \_\_\_\_\_

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**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.....

*W. J. Robert*

Licensed Embalmer No.....

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P. O. Address.....

*St. Louis, Mo.*

**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.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

40848-  
Do not use this space.

PLACE OF DEATH *St. Louis*  
 (a) County *St. Louis* Registration District No. *784*  
 (b) Township *Rich. Hts.* Primary Registration District No. *11* Registered No. *2126-*  
 (c) City *Rich. Hts.* (d) Street No. *St. Marys Hosp.* 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., of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *Michael J. McNamee*  
 (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

MEDICAL CERTIFICATE OF DEATH

3. SEX *m* 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  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR)  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hrs. or .....min.  
*58 9 24*  
 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. FUNERAL DIRECTOR (ADDRESS)  
 20. FILED, 19  
 Local Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Dec. 4 1934*  
 22. I HEREBY CERTIFY, That I attended deceased from  
 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:  
*Right atrial paralysis*  
*intermittent pressure*  
*of the coronary arteries*  
 Other contributory causes of importance:  
*53*  
 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 *N. F. Cunningham*, M. D.  
 (Signed) *Wm. J. Clark*  
 (Address) *Union, Ohio*

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.  
 CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION if very important.

