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V. S. No. 2
M—11-10-39
Rev. 5-17-39
I X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 8612

Registration District No. 7911 Primary Registration District No. 1003 Registrar's No. 2095

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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: Missouri Baptist Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis 5 (If outside city or town limits write "RURAL")

(d) Street No. 5559 Maple Ave. (If rural, give location)

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

3. (a) PRINT FULL NAME Olive Agnes Mc.Gaffigan,

3. (b) If veteran, name war

3. (c) Social Security No. 497-03-1230

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Nov. (Month) 7 (Day) 1886 (Year)

8. AGE: Years 53 Months 3 Days 22 If less than one day hr. min.

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

10. Usual occupation Office Manager

11. Industry or business Ira E. Whight Capitalist

FATHER
12. Name Dr. A.J. Mc.Gaffigan
13. Birthplace Brooklyn (City, town, or county) New York (State or foreign country)

MOTHER
14. Maiden name Ella Kennedy
15. Birthplace (City, town, or county) Penn. (State or foreign country)

16. (a) Informant Geo. Horn
(b) Address 5959 Maple Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3- 2- 40 (Month) (Day) (Year)
(c) Place: burial or cremation Carlyle, Illinois

18. (a) Signature of funeral director Cullinane Bros.
(b) Address 1710 N. Grand Blvd.

19. (a) MAR 1 1940 (Date received local registrar) (b) J F Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 29 year 1940 hour 2 minute 0 P. M.

21. I hereby certify that I attended the deceased from Nov -4-39, 19 to 2-29-, 1940 that I last saw her alive on Feb -29-, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Embolus	30 hours
Due to Chronic Myocarditis with Mitral Regurgitation	9 months
Due to and decompensation	
Other conditions None (Include pregnancy within 3 months of death)	
Major findings: Of operations No operation	
Of autopsy No autopsy	

PHYSICIAN — 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? (Specify type of place)
While at work? (e) Means of injury

23. Signature O.O. Smith M.D. (M. D. or other)
Address 536 N. Taylor St. Louis Mo Date signed 3/1/40

(Licensed Embalmer's Statement on Reverse Side)

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 Fred Frick

Licensed Embalmer No. 3186

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.