

Registration District No. **791** Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
CITY HOSPITAL No 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community Life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County _____
(c) City or town ST. LOUIS. 24
(If outside city or town limits, write "RURAL")
(d) Street No. 3545 S. 2nd St.
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME JAMES THOMAS McDERMOTT

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

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

6. (b) Name of husband or wife Mollie McDermott 6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased June 6th 1893
(Month) (Day) (Year)

8. AGE: Years 46 Months 9 Days 18 If less than one day hr. _____ min. _____

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

10. Usual occupation Butcher

11. Industry or business _____

12. Name Thomas Patrick McDermott

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

14. Maiden name Anna Saling

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

16. (a) Informant Mollie McDermott

(b) Address 3545 S 2nd St.

17. (a) Burial (b) Date thereof Mar 27/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director [Signature]

(b) Address 2906 Gravois Ave.

19. (a) MAR 25 1940 (b) J. F. Budich
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 24
year 1940 hour 4 minute 05 P.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Unrecorded Left Inguinal Hernia

Due to Spinal Anesthesia

Due to _____

Other conditions (Include pregnancy within 3 months of death) 122a

Major findings: Of operations _____

Of autopsy _____

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) _____ Means of injury _____

23. Signature [Signature] (M. D. or other) _____
Address [Signature] Date signed 3.25.40

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

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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 _____

Thos Lites

Registered Apprentice No. _____

working under my personal supervision.

Signed _____

Thos Lites

Licensed Embalmer No. _____

1619

P. O. Address _____

2906 Graves

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.