

FILED MAY 15 1940

Registration District No.

Primary Registration District No.

Registrar's No.

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:
6560 Smiley Ave.
(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)

8. (a) PRINT FULL NAME MARY E. MAXWELL 240

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

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

6. (b) Name of husband or wife John J. Maxwell 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased. Jan. 2. 1862
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
78 3 18 ..hr. min.

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

10. Usual occupation at home

11. Industry or business..... 5

MOTHER FATHER { 12. Name Michael Kane
13. Birthplace Dublin Ireland
(City, town, or county) (State or foreign country)

{ 14. Maiden name Catherine Garahan
15. Birthplace Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant Anne F. Maxwell (daughter)

(b) Address 6560 Smiley Ave.

17. (a) Burial (b) Date thereof 4/23/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director M.J. Croghan

(b) Address 7146th Manchester Ave.

19. (a) APR 22 1940 (b) J.P. [Signature]
(Date received local registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County.....
D St. Louis 3
(c) City or town St. Louis
(If outside city or town limit, write "RURAL")
(d) Street No. 6560 Smiley Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A.?..... years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 20
year 1940 hour 4 minute 00 P.M.

21. I hereby certify that I attended the deceased from Feb. 17, 1940, to Apr. 21, 1940
that I last saw her alive on Apr. 21, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death: Myocardial insufficiency Chronic

Due to Chronic Myocarditis & Chronic Nephritis
Due to Generalized Arteriosclerosis

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations..... 131
Of 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?

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

23. Signature A.T. Quinn (M. D. or other)
Address 6917 Foyles ave Date signed 4/22/40

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

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 *Francis A. Williamson*

Licensed Embalmer No. *3865*

P. O. Address *3146 Manchester*

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.