

Registration District No. 791

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:  
4453 Clarence Ave 2  
(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 Ellen McGrath 263  
 8. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if Daniel McGrath Deceased alive \_\_\_\_\_ years  
 7. Birth date of deceased Oct 19 1859  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
80 6 28 \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace St. Louis Missouri 0  
(City, town, or county) (State or foreign country)

10. Usual occupation At Home 1

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name John Burnett 6  
 18. Birthplace Penn  
(City, town, or county) (State or foreign country)  
 14. Maiden name Catherine McGrath  
 15. Birthplace St. Louis Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Catherine McGrath  
 (b) Address 4453 Clarence Ave

17. (a) Burial (b) Date thereof 5/21/40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Stroot - Carroll  
 (b) Address 4600 Natural Bridge Ave

19. (a) MAY 18 1940 (b) J. F. Bruders  
(Date received local registrar) (Signature of registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
 (c) City or town St. Louis 9  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 4453 Clarence Ave  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 17th  
 year 1940 hour 7 minute 55 a. M.

21. I hereby certify that I attended the deceased from May 7, 1940 to May 17, 1940  
 that I last saw him alive on May 16, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Ch. Myocarditis  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

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

PHYSICIAN \_\_\_\_\_  
 Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
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 Ed Leving (M. D. or other) M.D.  
 Address 2242 Ashmun Date signed 5/17/40

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

*Frank H. Stout*

Licensed Embalmer No. 2265

P. O. Address .....

**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.**