

Registration District No. FILED ON 7 7 1940

Primary Registration District No. 1003

Registrar's No.

1. PLACE OF DEATH:

(a) County 1
(b) City or town ST. LOUIS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
CITY HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 weeks
(Specify whether
In this community LIFE
years, months or days) 257

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County _____
(c) City or town ST. LOUIS 6
(If outside city or town limits, write "RURAL")
(d) Street No. 5754A EASTON AVE.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

8. (a) PRINT FULL NAME CHARLES EMAGINNIS

8. (b) If veteran, name war No 8. (c) Social Security No. 488-07-9443

4. Sex MALE 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 Sept 5 1878
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
61 8 29 _____ hr. _____ min.

9. Birthplace ST. LOUIS MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation WATCHMAN

11. Industry or business MAJESTIC RANGE CO.

12. Name HUGH MAGINNIS

18. Birthplace UNKNOWN ENGLAND
(City, town, or county) (State or foreign country)

14. Maiden name MARY AHEARN

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

16. (a) Informant Agnes B. Maginnis

(b) Address 5754A EASTON AVE

17. (a) BURIAL (b) Date thereof 6-5-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY

18. (a) Signature of funeral director Hollen & Kelly

(b) Address 1416 N. Taylor Ave.

19. (a) JUN 4 1940 (b) J. P. Bredeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 30
year 1940 hour 6 minute 30 A. 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 Fractured brow in right side of face, fractured nose, fracture of orbital rim, fracture of base of skull, suffocation, undecayed, all things flight of heart, down his head April 19 1940 about 4 hr

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accidental

(b) Date of occurrence Apr 19 1940

(c) Where did injury occur? at home
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
6 Home

While at work? _____ (Specify type of place)
Means of injury fell

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

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

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

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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

Clement McNeary

Licensed Embalmer No. 3732

P. O. Address

St. Louis

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.