

Registration District No. **757**

Primary Registration District No. **3036**

Registrar's No. **176**

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

1. PLACE OF DEATH:
 (a) County St. Charles **3**
 (b) City or town St. Charles
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Carnalite Home
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 1/2 yrs.
(Specify whether years, months or days)
 In this community 11 1/2 years

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County St. Charles
 (c) City or town St. Charles
(If outside city or town limits, write "RURAL")
 (d) Street No. Carnalite Home
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Patrick M. Mc Grail
 3. (b) If veteran, name war No
 3. (c) Social Security No. None

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month July day 18
 year 1946 hour Eight minute 40 A. M.
 21. I hereby certify that I attended the deceased from June 6, 1940
1944, to July 18 1946
 that I last saw him alive on July 17 1946
 and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife Mc Grail 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased March 14 - 1864
(Month) (Day) (Year)

Immediate cause of death Atherosclerosis
 Duration 5 yrs.

8. AGE: Years 76 Months 4 Days 4 If less than one day hr. _____ min.

Due to _____
 Due to _____

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

Other conditions Common of face
(Include pregnancy within 3 months of death) 8 yrs

10. Usual occupation Mechanic

11. Industry or business Bell Telephone Co

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Carnalite Sisters
 (b) Address St. Charles, Mo.

17. (a) Burial (b) Date thereof July 20 - 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery - St. Louis, Mo.

18. (a) Signature of funeral director N.C. Dillmeier & Sons Co.

(b) Address 800 N. Second, St. Charles, Mo.

19. (a) 7/18/46 (b) Clarence H. Hessler
(Date received local registrar) (Registrar's signature)

Major findings:
 Of operations _____
 Of autopsy none

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? _____

(e) Means of injury _____
(Specify type of place) (e) Means of injury

23. Signature B.L. Newbaker (M. D. or other) MD
 Address St. Charles, Mo. Date signed 7/19/46

52

72

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.....

Joseph Landolt....., Registered Apprentice No. ~~242~~ 243
working under my personal supervision.

Signed John B. Dalmeier.....

Licensed Embalmer No. 2951

P. O. Address St Charles 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **36128**
Registrar's No. **126**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **757**

Primary Registration District No. **3036**

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

1. PLACE OF DEATH:

(a) County **St. Charles**
(b) City or town **St. Charles**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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

3. (a) PRINT FULL NAME **Patricia M. McGrail**

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

4. Sex **m** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **wid**

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

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

8. AGE: Years **76** Months **4** Days **4** If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof. (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

20. DATE OF DEATH: Month **July** day **18** year **1949** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that last saw h. _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death **arteriosclerosis** Duration _____

Due to _____

Due to _____ **45**

Other conditions **Carcinoma of face**
(Include pregnancy within 3 months of death)
check (left)

Major findings: **Basal Cell type**

Of operations _____

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?

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

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

*Address _____ Date signed _____

SUPPLEMENTARY

