

2  
3-40  
7-39  
X2115

Registration District No. 784

Primary Registration District No. 101

Registrar's No. 2161

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Clayton  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
St. Louis County Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days  
(Specify whether

In this community life  
years, months or days)

3. (a) PRINT FULL NAME Rose Mary McGill

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex female 5. Color or race colored

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 Nov. 12 1940  
(Month) (Day) (Year)

8. AGE: Years : Months Days If less than one day

0 0 2 \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation nil. 0

11. Industry or business 0

12. Name Fred McGill 0

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

14. Maiden name Flora Unknown

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

16. (a) Informant Clayton Board

(b) Address St. Louis County Hosp. Clayton

17. (a) Removed (b) Date thereof 11-15-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Anatomical Board

18. (a) Signature of funeral director St. Louis County Hosp. Clayton

(b) Address N. + S. rd. Clayton, Mo.

19. (a) NOV 15 1940 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis

(c) City or town S. Kinloch Park  
(If outside city or town limits, write "RURAL")

(d) Street No. Monroe and Scudder Aves.  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 14  
year 1940 hour 7 minutes 50 A. M.

21. I hereby certify that I attended the deceased from 11-12-40  
\_\_\_\_\_, 19\_\_\_\_, to 11-14-40, 19\_\_\_\_;

that I last saw her alive on 11-14-40, 19\_\_\_\_;

and that death occurred on the date and hour stated above.

Immediate cause of death Prognathia Duration  
Stenosis approximately 7 months

Due to \_\_\_\_\_

Due to 159

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
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? \_\_\_\_\_

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

23. Signature [Signature] (M. D. or other) \_\_\_\_\_

Address Clayton Date signed \_\_\_\_\_

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

MOTHER FATHER

**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.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**