

No. 2
-1-4-41
5-17-39
I X26390

JUN 6 1941
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 19049
Registrar's No. 1166

Registration District No. 784 Primary Registration District No. 111

96
908
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County St. Louis.
(b) City or town Richmond Heights.
(c) Name of hospital or institution:
St. Marys Hospital.
(d) Length of stay: In hospital or institution 4 Days.
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Margaret Pattison.
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 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. Unknown 1886
(Month) (Day) (Year)

8. AGE: Years 55 Months — Days — If less than one day _____ hr. _____ min.

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

10. Usual occupation At Home.

11. Industry or business _____

MOTHER FATHER { 12. Name Thomas Pattison.
13. Birthplace Ireland. (City, town, or county) (State or foreign country)

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

16. (a) Informant Miss Rose Pattison.
(b) Address 1414 McCausland Ave.

17. (a) Burial (b) Date thereof 6-5-41.
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery
18. (a) Signature of funeral director Arthur J. Gernemelly
(b) Address 3840 Lindell Blvd.

19. (a) JUN - 4 1941 (b) R. W. Miller, M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 000
(a) State Mo. (b) County _____
(c) City or town St. Louis. (If outside city or town limits, write "RURAL.")
(d) Street No. 1414 McCausland Ave. (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month June day 2nd
year 1941 hour 5:20 minute. P. M.
21. I hereby certify that I attended the deceased from er
May 15, 1941 to June 2, 1941.
that I last saw er alive on June 2, 1941
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Bronchopneumonia
arteriosclerosis
Due to _____
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy same as above

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 Thomas M. Martin (M. D. or other) _____
Address 634 N. Grand Date signed 6/9

(Licensed Embalmer's Statement on Reverse Side)

3-130
New York
No. 6633

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 Stanley Marshall
Licensed Embalmer No. 2868
P. O. Address 3840 Lindell

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, fact should be so stated above.