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4-13-40  
5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **33212**  
Registrar's No. **8167**

FILED NOV 24 1941

Registration District No. **791** Primary Registration District No. **1003**

1. PLACE OF DEATH:  
(a) County \_\_\_\_\_  
(b) City or town **St. Louis, Missouri**  
(c) Name of hospital or institution **St. Louis City Hospital #1**  
(d) Length of stay: In hospital or institution **5 Days**  
In this community \_\_\_\_\_ years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County \_\_\_\_\_  
(c) City or town **St. Louis**  
(d) Street No. **1129 N Grand**  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME **Catherine McKenrow**  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **October** day **11**, year **1941** hour **12:30** minute \_\_\_\_\_ P. M.

4. Sex **Female** 5. Color of hair **White** 6. (a) Single, widowed, married, divorced **Widow**  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

21. I hereby certify that I attended the deceased from **October 7**, 19 **41** to **October 11**, 19 **41** that I last saw her alive on **October 11**, 19 **41** and that death occurred on the date and hour stated above.

7. Birth date of deceased **Feb 14** (Month) (Day) (Year)  
8. AGE: Years **75** Months **8** Days **27** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death **Cerebrovascular thrombosis right middle cerebral artery** 4 days  
Due to **Chr. myocardial disease** 4 yrs  
**Cor. arteriosclerosis**

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)  
10. Usual occupation **Secretary**

Due to **Pulmonary emphysema** 20+ yrs  
**Phalanges of left hand** 8 yrs  
Other conditions **Old fracture rt tibia** 30 yrs, **left wrist** old  
PHYSICIAN \_\_\_\_\_

MOTHER FATHER { 11. Industry or business **Occupational therapy**  
12. Name **Anderson**  
13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy **none granted**  
Underline the cause to which death should be charged statistically.

16. (a) Informant **Mrs. Marion Clark**  
(b) Address **4715 West Margate**  
17. (a) **Burial** (b) Date thereof **Oct 15 1941**  
(c) Place: burial or cremation **Calvary Cem**

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? \_\_\_\_\_

18. (a) Signature of funeral director **J. V. Mulligan**  
(b) Address **5041 Delmar**  
19. (a) **J. F. Brebeck** (b) \_\_\_\_\_ (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature **L. V. Mulligan** (M. D. or other) \_\_\_\_\_  
Address **1515 Lafayette Ave** Date signed **10/14/41**

OCT 24 1941

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 *Howard F. Rawls*.....

Licensed Embalmer No. *3114*.....

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, fact should be so stated above.**