

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Dr. Steinmann
5428 Magnolia 568
State File No.

FILED FEB 24 1947 91

1003

Registrar's No. 659

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution 6445 Nashville
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1
(Specify whether _____)
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 6445 Nashville
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 21st
year 1942 hour 7 minute 30 A.M.

21. I hereby certify that I attended the deceased from Dec. 28, 1941 to Jan 21, 1942
that I last saw h. er. alive on Jan 30, 1942
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Artery Disease
Duration _____
Due to 2

Other conditions Arterio-Sclerosis
(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 W.H. Steinmann M.D. (M.D. or other) _____
Address 5428^a Magnolia Date signed 1/21/42

3. (a) PRINT FULL NAME MARY WALSH Mc GORMICK

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Divorced
6. (b) Name of husband or wife John Mc Cormick 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Feb. 28, 1861
(Month) (Day) (Year)

8. AGE: Years 80 Months 10 Days 23
If less than one day _____ hr. _____ min.

9. Birthplace Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business Housewife

MOTHER FATHER

12. Name Michael Walsh

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

14. Maiden name Hannah Regan

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

16. (a) Informant Mrs. Mary Mc Magness

(b) Address 6445 Nashville, St. Louis

17. (a) Burial (b) Date thereof 1-23-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peter's Cemetery, Kirkwood

18. (a) Signature of funeral director Louis A. Gosselink

(b) Address 131 W. Regan Dr. Kirkwood, Mo.

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

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

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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.....

Corrie H Bopp

....., Registered Apprentice No.....

working under my personal supervision.

Signed *Corrie H Bopp*

Licensed Embalmer No. *921*

P. O. Address *Pickwood 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, fact should be so stated above.