

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 12008
Registrar's No. 843

Registration District No. 184

Primary Registration District No. 101

APR 20 1942

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 1 mo. 16 days
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County St. Louis
(c) City or town Baden Station
(If outside city or town limits, write "RURAL")
(d) Street No. Larrimore & Trampe Rd. Rt. #3
(If rural, give location)
(e) If foreign born, how long in U. S. A.? No years.

3. (a) PRINT FULL NAME Leo McCally
3. (b) If veteran, name war unknown
3. (c) Social Security No. unknown

20. DATE OF DEATH: Month March day 3
year 1942 hour 10 minute :30 A. M.

4. Sex male 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 Aug. 20 1870
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 1-15-42, 19____, to 3-3-42, 19____; that I last saw him alive on 3-3-42, 19____; and that death occurred on the date and hour stated above.

8. AGE: Years	Months	Days	If less than one day
<u>71</u>	<u>6</u>	<u>11</u>	hr. _____ min.

Immediate cause of death:
Generalized ulceration of central nervous system - 3 mos.
Due to Generalized ulceration of central nervous system - 3 mos.
Due to Central nervous system - 3 mos.

9. Birthplace Unknown Ky. 1
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations 30C
Of autopsy _____

10. Usual occupation farm laborer
11. Industry or business _____
MOTHER FATHER { 12. Name Lisander McCally
13. Birthplace Parkersburg W. Va. 1
(City, town, or county) (State or foreign country)
14. Maiden name Mary Parker
15. Birthplace Parkersburg W. Va. 1
(City, town, or county) (State or foreign country)

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) (e) Means of injury _____

16. (a) Informant's own signature E. Brown (St. L. Co. Hosp.)
(b) Address 501 S. Brentwood, Clayton, Mo.
17. (a) Cremation (b) Date thereof 4-16-42
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St. Louis Crematory
18. (a) Signature of funeral director E. Brown, St. L. Co. Hosp.
(b) Address 501 S. Brentwood, Clayton, Mo.
19. APR 16 1942 (Date received local registrar) (c) E. H. Mc (Registrar's signature)

23. Signature J. H. Brown (M. D. or other) JWB
Address St. Louis Co. Hospital Date signed 3-3-42

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Rev. 6-17-39
FORM 10-1-1931

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 comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

6201 12 99