

FILED MAR 11 1943
Registration District No. _____

Primary Registration District No. 200

Registrar's No. 448

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
Mount St. Rose Sanatorium
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9/7/42 to 2/21/43
(Specify whether years, months or days)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

(c) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL")

(d) Street No. 4617 Lexington Ave.
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME McKenzie, William

3. (b) If veteran, name war _____

3. (c) Social Security No. 486-16-0364

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mary McKenzie

6. (c) Age of husband or wife if alive 51 years

7. Birth date of deceased: Nov 11 1889
(Month) (Day) (Year)

8. AGE: Years 53 Months 3 Days 9
If less than one day hr. min.

9. Birthplace Jefferson City Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Shoe Worker

11. Industry or business _____

MOTHER FATHER { 12. Name William McKenzie

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

14. Maiden name Frances Kohlmeier

15. Birthplace Unknown 7
(City, town, or county) (State or foreign country)

16. (a) Informant Mary McKenzie

(b) Address 4617 Lexington Ave

17. (a) Burial (b) Date thereof 2/25/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Stroot - Carroll

(b) Address 4600 Natural Bridge Ave

19. (a) FEB 24 1943 (b) C. D. McLaughlin M.D.
(Date of issue) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 21
year 1943 hour 10 minute 10 P.M.

21. I hereby certify that I attended the deceased from 9/7 1942 to 2/21 1943; that I last saw her alive on 2/21 1942 and that death occurred on the date and hour stated above.

Immediate cause of death Grav. Advanced Pulmonary Tuberculosis

Due to _____

Due to _____

Other conditions The epididymitis + The enteritis
(Include pregnancy within 3 months of death)

Major findings: 1361

Of operations _____

Of autopsy _____

Duration 2 yrs

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 Johanna B. Muehl (M. D. or other) M.D.
Address 701 S. Broadway Date signed 2/22/43

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

McA

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..... *A. Detroit*

Licensed Embalmer No. *2265*

P. O. Address *4600 Natural Bui*

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.