

S. No. 2
M-9.4.41
5-17-39
PI X2948

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

11962
3186

State File No.

Registrar's No.

FILED APR 19 1943 18

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County.....
(b) City or town..... **ST. LOUIS**
(c) Name of hospital or institution: **VISITATION ACADEMY 5448 CABANNE AVE**
(d) Length of stay: In hospital or institution..... **51 YEARS**
In this community..... **51 YEARS**

2. USUAL RESIDENCE OF DECEASED:

(a) State..... **MO.** (b) County.....
(c) City or town..... **ST. LOUIS**
(d) Street No..... **5448 CABANNE AVE.**
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **SISTER MARY CAMILLA**

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..... **APRIL 17, 1870**

8. AGE: Years Months Days If less than one day
72 11 16 hr. min.

9. Birthplace..... **DONT KNOW / PENNSYLVANIA**

10. Usual occupation..... **RELIGIOUS**

11. Industry or business.....

12. Name..... **MICHAEL McBRIDE** **IRELAND**

13. Birthplace..... **ANN McBRIDE** (State or foreign country)

14. Maiden name..... **IRELAND**

15. Birthplace..... **SISTER BAPTISTA BAKER**

16. (a) Informant..... **5448 CABANNE AVE.**

17. (a) **BURIAL** (b) Date thereof..... **4-5-43**

(c) Place: burial or cremation..... **CALVARY CEMETERY**

18. (a) Signature of funeral director..... **3840 Lindell Blvd**

(b) Address..... **APR 4 1943**

19. (a) (Date received local registrar)..... (Registrar's signature).....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... **APRIL** day..... **3** year..... **1943** hour..... **10** minute..... **A.** M.

21. I hereby certify that I attended the deceased from..... **January 10th** 1940 to..... **April 10th** 1943 that I last saw her alive on..... **April 9th** 1943 and that death occurred on the date and hour stated above.

Immediate cause of death..... **Hypertensive Cardiovascular disease** Duration **3 years**

Due to..... Due to.....

Other conditions..... (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..... **Augustus P. Munsch** (M. D. or other) Address..... **306 N. Humboldt Blvd** Date signed..... **4/3/43**

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

MOTHER FATHER

*Dr A P Memorial
Memorial - 1954*

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.