

S. No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16360
State File No. _____
Registrar's No. **4469**

Registration District No. **318**

Primary Registration District No. **1002**

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

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:
4453 A HOLLY AVE.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community **1 YEAR** (Specify whether 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. **4453 A HOLLY AVE.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **MARY McKANNA**
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **MAY** day **12**
year **1943** hour **8** minute **10 P.M.**
21. I hereby certify that I attended the deceased from **May 10**
1943 to **May 12**, 1943
that I last saw her alive on **May 12**, 1943
and that death occurred on the date and hour stated above.

4. Sex **FEMALE** 5. Color or race **WHITE**
6. (a) Single, widowed, married, divorced, **WIDOW**
6. (b) Name of husband or wife **ATHOME McKANNA**
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **OCT. 16 1865**
(Month) (Day) (Year)

Immediate cause of death: **Chronic Interstitial nephritis**
Duration **Don't know**
Due to _____
Due to _____
Other conditions: **General hypertension**
(Include pregnancy within 3 months of death)

8. AGE: Years **77** Months **6** Days **16**
If less than one day _____ hr. _____ min.

PHYSICIAN _____
Underline the cause to which death should be charged statistically.
Major findings: _____
Of operations _____
Of autopsy _____

9. Birthplace **SYRCAUSE OHIO**
(City, town, or county) (State or foreign country)
10. Usual occupation **AT HOME**

MOTHER {
11. Industry or business _____
12. Name **THOMAS R. WILLIAMS**
13. Birthplace **WHALES 4**
(City, town, or county) (State or foreign country)
14. Maiden name **LETTIE PHILLIPS**
15. Birthplace **WALES 4**
(City, town, or county) (State or foreign country)

16. (a) Informant **MRS. WALTER MATTICK**
(b) Address **4453 A HOLLY AVE.**
17. (a) **REMOVAL** (b) Date thereof **5-13-43**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **OSKALOOSA IOWA**
18. (a) Signature of funeral director **Arthur J. Donnelly**
(b) Address **3840 LINDELL BLVD**
19. (a) **MAY 13 1943** (b) **J. F. Bradlek**
(Date received local registrar) (Registrar's signature)

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 **P. R. Menown** (M. D. or other) **MD**
Address **5330 Geraldine** Date signed **5-13-43**

H
1948
5330
Bennett
8.10

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 Luddell Blvd

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.