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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 25 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 22447

Registration District No. 317 Primary Registration District No. 2007 Registrar's No. 1447

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution: 1023 E. Park Pl. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether In this community 70 Yrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town University City (If outside city or town limits, write "RURAL")

(d) Street No. 1023 E. Park Pl. (If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No) If yes, name country 0

3. (a) PRINT FULL NAME Catherine B. Mc Cabe

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife James J. Mc Cabe

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

7. Birth date of deceased Feb. (Month) 1, (Day) 1866 (Year)

8. AGE: Years 77 Months 4 Days 18 If less than one day ..... hr. ..... min.

9. Birthplace Winchester (City, town, or county) Ill. (State or foreign country)

10. Usual occupation At Home

11. Industry or business

FATHER
12. Name Michael Costello
13. Birthplace ..... (City, town, or county) Ireland (State or foreign country)

MOTHER
14. Maiden name Johanna English
15. Birthplace ..... (City, town, or county) Ireland (State or foreign country)

16. (a) Informant Kathryn Mc Cabe
(b) Address 1023 E. Park Pl.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-23-43 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Stroot Carroll
(b) Address 4600 Natural Bridge

19. (a) JUN 28 1943 (Date received local registrar) (b) E. H. McGarvey M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 19 year 1943 hour 1 minute A. M.

21. I hereby certify that I attended the deceased from Feb 22, 1934, to June 19, 1943; that I last saw her alive on June 19, 1943; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Coronary Occlusion	1/2 hr
Due to Chr Myocard Disease	1 yr
Due to Hemiplegia, Old	9 1/4 yrs

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? ..... (Specify type of place)

While at work? ..... (e) Means of injury 0

23. Signature R. Nakada (M. D. or other)

Address Humboldt Bldg Date signed 6/21/43

(Licensed Embalmer's Statement on Reverse Side)

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 Sheldon Collier

Licensed Embalmer No. 3382

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, fact should be so stated above.