

FILED JAN 3 1948
Registration District No. **1003**

Primary Registration District No. _____

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

1. PLACE OF DEATH:

(a) County ST. LOUIS

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

(c) Name of hospital or institution:
3921 A ASHLAND AVE. /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether)

In this community 20 YEARS
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County 17

(c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")

(d) Street No. 3921 A ASHLAND AVE.
(If rural, give location)

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

3. (a) PRINT FULL NAME MARGARET M McCUE

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 WIDOW

6. (b) Name of husband or wife THOMAS McCUE

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

7. Birth date of deceased DEC. 25, 1870
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>72</u>	<u>11</u>	<u>27</u>	hr. _____ min. _____

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

10. Usual occupation AT HOME

11. Industry or business _____

MOTHER FATHER

12. Name JOHN HANNAHUE

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

14. Maiden name CATHERINE GUILBOY

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

16. (a) Informant MRS. KATE KELLERMAYER

(b) Address 3921 A ASHLAND AVE.

17. (a) Burial (b) Date thereof 12-27-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MOUNT CARMEL CEMETERY

18. (a) Signature of funeral director Arthur J. Donnelly

(b) Address 3840 Lindell Blvd

19. (a) DEC 23 1947 (b) J. F. Bessard
(Date received for local registration) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DEC. day 22
year 1947 hour 10 minute 45 A. M.

21. I hereby certify that I attended the deceased from Nov 20 1947 to Dec 22 1947
that I last saw her alive on Dec 22 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Wrenia Duration 6 Wks

Due to Chronic Duration 6 Wks

Due to depression with edema

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 J. F. Bessard (M. D. or other) _____
Address 4114 W 20th St Date signed 12/24/47

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.