

S. No. 2
OM-5-43
v. 5-17-39
I X36571

FILED FEB 18 1944 818

Registration District No. _____ Primary Registration District No. 1003

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: BARNES HOSPITAL 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 36 days
In this community _____ years, months or days (specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County McLean
(c) City or town Normal
(If outside city or town limits, write "RURAL")
(d) Street No. 914 Division
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country 2

3. (a) PRINT FULL NAME Angeline Alice McMahon

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 Married
6. (b) Name of husband or wife Cashman McMahon 6. (c) Age of husband or wife if alive 54 n years
7. Birth date of deceased Sept 12 1894
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
49 4 26 _____ hr. _____ min.

9. Birthplace Madison Illinois
(City, town, or county) (State or foreign country)
Housewife

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Sherman Cook
13. Birthplace Unknown Unknown 9
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Cashman McMahon
(b) Address Normal, Ill.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 2-8-44
(Month) (Day) (Year)
(c) Place: burial or cremation Bloomington, Ill.

18. (a) Signature of funeral director Albert H. Hoppe Inc.
(b) Address 4700 Washington Blvd.

19. (a) FEB 8 1944 (Date received local registrar) (b) J. F. Braden (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 8 year 1944 hour 3 minute A. M.

21. I hereby certify that I attended the deceased from Jan. 3, 1944, to Feb. 8, 1944; that I last saw her alive on Feb. 8, 1944; and that death occurred on the date and hour stated above.

Immediate cause of death BRAIN TUMOR UNVERIFIED

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy HEMATOMA.

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 0

23. Signature J. R. Braden (M. D. or other) _____
Address BARNES HOSPITAL Date signed 2/8/44

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.....

..... Licensed Embalmer No..... 1861

..... 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.