

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No.

13076

FILED APR 26 1944

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 3553

1. PLACE OF DEATH:

(a) County.....  
(b) City or town..... St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Louis City Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 days  
(Specify whether in this community years, months or days)

3. (a) PRINT FULL NAME Marie McGhay

3. (b) If veteran, name war no 3. (c) Social Security No. none

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 October 30, 1902  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
41 5 16 hr. min.

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

10. Usual occupation Unemployed

11. Industry or business.....

12. Name James McGhay  
13. Birthplace Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Nellie Kelly  
15. Birthplace Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Pearl Slaten  
(b) Address 1452a Madison St.

17. (a) Burial (b) Date thereof 4-19-44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Concordia Cemetery

18. (a) Signature of funeral director Hy. Leidner Und. Co.  
(b) Address 2223 St. Louis Ave.

19. (a) APR 18 1944 (b) J. J. Brundick  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1452a Madison St.  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 16th  
year 1944 hour 5:15 minute A. M.

21. I hereby certify that I attended the deceased from April 11th  
....., 19 44 to April 16th, 19 44  
that I last saw h. or alive on April 16th, 19 44  
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertension  
heart disease Duration

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 Tracy (M. D. or other) un  
Address 1515 Lafayette Date signed 4/17/44

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

**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. 1674

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.**