6. No. 2
M—2-43
5-17-39
P I X35897

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 8 1944

Registration District No. 317

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6076

State File No. 15816

Registrar's No. 1031

1. PLACE OF DEATH:

(a) County: St. Louis

(b) City or town: Manchester, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Manchester Nursing Home
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)

In this community _____

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County: 000

(c) City or town: St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No.: 4729 Hammett Pl.,
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME: Michael P. McCabe. MCCABE MICHAEL P.

3. (b) If veteran, name war: No

3. (c) Social Security No.: None

4. Sex: Male

5. Color or race: White

6. (a) Single, widowed, married, divorced: Widowed

6. (b) Name of husband or wife: Mary McCabe

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

7. Birth date of deceased: Dec. 25, 1844. (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
99	4	6	_____ hr. _____ min.

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

10. Usual occupation: Retired

11. Industry or business _____

FATHER
12. Name: John McCabe
13. Birthplace: Unknown (City, town, or county) Ireland (State or foreign country)

MOTHER
14. Maiden name: Don't Know
15. Birthplace: Unknown (City, town, or county) Ireland (State or foreign country)

16. (a) Informant: David McCabe
(b) Address: 4729 Hammett Pl.,

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: May 4/44. (Month) (Day) (Year)
(c) Place: burial or cremation: Calvary Cem.,

18. (a) Signature of funeral director: Jos. W. Clark
(b) Address: 1125 Hodiamont Ave.,

19. (a) MAY 4 - 1944 (Date received local registrar) (b) E. H. McGavran, M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: May 1st day: 1st year: 1944 hour: 7 minute: 30 P.M.

21. I hereby certify that I attended the deceased from April 6, 1944, to May 1st, 1944, that I last saw him alive on April 30, 1944, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Chronic myocarditis	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations: 930	
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

23. Signature: A. L. Merlem M.D. (M. D. or other)

Address: 350 Polaski Date signed: 5-2-44

(Licensed Embalmer's Statement on Reverse Side)

Dr. A.L.Mirklin,
3507 Potomac Ave., St. Louis
GR. 1863.

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 Jas. W. Clark

Licensed Embalmer No. 1661

P. O. Address 1125 Hodiamont Ave.,

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.