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13
39
97823

FILED JUN 23 1944
Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **5432**

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:
Mo. Baptist Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days) 0

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____

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

(d) Street No. 7611 Virginia
(If rural, give location)

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

3. (a) PRINT FULL NAME Mary McDonald

3. (b) If veteran, name war No. 3. (c) Social Security No. No.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife William 6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased Oct. 30 1891
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 14
year 1944 hour 10.00 minute _____ P.M.

21. I hereby certify that I attended the deceased from 6/13/44 to 6/14/44
that I last saw her alive on 6/14/44 and that death occurred on the date and hour stated above.

8. AGE: Years 52 Months 7 Days 14
If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name John J. McCarthy

13. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Anna Lovett

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

Immediate cause of death
1. Cyphosis of spine
2. Hypertension
3. Atherosclerosis (Chronic)
4. Secondary anemia

Duration _____

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

Major findings:
Of operations 1/2H

Of autopsy _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER

16. (a) Informant William McDonald
(b) Address 7611 Virginia

17. (a) Burial (b) Date thereof 6/17/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Olive Cemetery

18. (a) Signature of funeral director Jos. P. ...
(b) Address 7128 Michigan

19. (a) JUN 16 1944 (b) J. F. ...
(Date received local registrar) (Registrar's signature)

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) Means of injury _____

23. Signature J. F. ... (M. D. or other) _____
Address 2639 ... Date signed 6/16/44

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

STATEMENT BY LICENSED EMBALMER

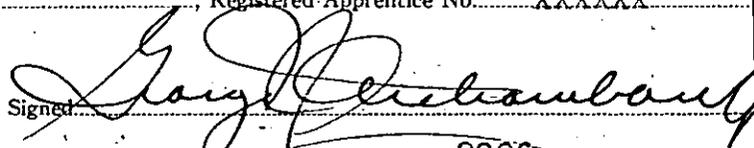
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

George N. Archambault

Registered Apprentice No. XXXXXX

working under my personal supervision.

Signed.....



Licensed Embalmer No. 2906

P.O. Address 3013 Meramec St.

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.