

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **22972**  
**6755**  
Registrar's No.

FILED AUG 8 1944  
Registration District No. **318**

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: 4046 Maffitt 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 \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000  
(c) City or town St. Louis 12  
(If outside city or town limits, write "RURAL") 911  
(d) Street No. 4046 Maffitt Ave.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME Rose Ann Fahey  
(b) If veteran, name war No  
(c) Social Security No. None

4. Sex Female / 5. Color or race White  
6. (a) Single, widowed, married, divorced Widow  
6. (b) Name of husband or wife Patrick Fahey  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased June 6 1855  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>89</u>	<u>1</u>	<u>26</u>	hr. _____ min.

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

10. Usual occupation at Home

11. Industry or business \_\_\_\_\_

12. Name Philip Mc. Evinney

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

14. Maiden name Susie Ann Cusick

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

16. (a) Informant Mrs. Patrick Clarkson

(b) Address 4046 Maffitt Ave

17. (a) Burial (b) Date thereof 8-4-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery Cullinane Bros.

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address 1710 N. Grand Blvd.

19. (a) AUG 2 1944 (b) J. T. Beedeck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 1  
year 1944 hour 2 minute 45 p. M.  
21. I hereby certify that I attended the deceased from July 10-24  
1944, to July 31, 1944  
that I last saw her alive on July 31, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 7 days  
Due to Hypertension  
Due to \_\_\_\_\_  
Other conditions none  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy no

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

22. If death was due to external causes, fill in the following: no  
(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 J. T. Beedeck (M. D. or other) \_\_\_\_\_  
Address 1816 N. Grand Date signed Aug 2-44

**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..... *Fred Frick* .....

Licensed Embalmer No. .... 3186 .....

P. O. Address..... St. Louis, Mo. ....

**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.**