

FILED AUG 21 1944 318

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town **St. Louis**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **DePaul Hosp**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **9 Days**. (Specify whether  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **000**  
(c) City or town **St. Louis** **17**  
(If outside city or town limits, write "RURAL") **6**  
(d) Street No. **4921 Cote Brillante**  
(If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country **0**

3. (a) PRINT FULL NAME **George E. McCarthy**

3. (b) If veteran, name war **None** 3. (c) Social Security No. \_\_\_\_\_

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

6. (b) Name of husband or wife **Annie T.** 6. (c) Age of husband or wife if alive **65** years

7. Birth date of deceased **Nov 22nd. 1874**  
(Month) (Day) (Year)

8. AGE: Years **69** Months **8** Days **15** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace **St. Louis** **No**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Maintenance Dept.**

11. Industry or business **Bell Telephone Co**

12. Name **John McCarthy**

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

14. Maiden name **Mary Bondi**

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

16. (a) Informant **Mrs Annie T. McCarthy**

(b) Address **4921 Cote Brillante Ave.**

17. (a) **Burial** (b) Date thereof **8/10/44**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cent.**

18. (a) Signature of funeral director **Haganigan & Sheahan Und Co**

(b) Address **4415 Washington Blvd.**

19. (a) **AUG 9 1944** (b) **J. T. Brueck**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **7th.**  
year **1944** hour **6:30 PM** mte. \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from **March 15**, 19**41**, to **Aug 7**, 19**44**  
that I last saw him alive on **Aug 7**, 19**44**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Hypostatic pneumonia following Catarrh removal**  
Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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 **Robert F. Hestey** (M. D. or other) \_\_\_\_\_  
Address **634 W. Grand Ave.** Date signed **Aug 8 1944**

Duration

**3 days**

PHYSICIAN

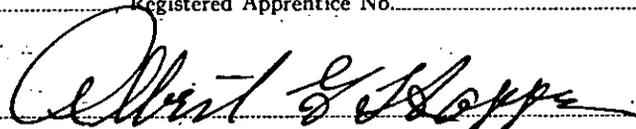
Underline the cause to which death should be charged statistically.

344 (Licensed Embalmer's Statement on Reverse Side)

**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. 2971

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.**