

FILED DEC 15 1944 318
Registration District No.

Primary Registration District No. 1003

Registrar's No. 10399

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 1331 Laurel
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Louis

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

(d) Street No. 1331 Laurel
(If rural, give location)

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

3. (a) PRINT FULL NAME Margaret M. Cahill

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

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

(b) Name of husband or wife _____ (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 4 1882
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 4 year 1944 hour _____ minute 30 A.M.

21. I hereby certify that I attended the deceased from March 18th 1943 to Dec 4th 1944

that I last saw her alive on Nov 13th 1944 and that death occurred on the date and hour stated above.

8. AGE: Years 62 Months 5 Days 0 If less than one day _____ hr. _____ min.

Immediate cause of death Arterio-Sclerotic Myocarditis Duration 6 mos.

Due to Arterio-Sclerosis 13 years

Due to 93

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

10. Usual occupation at Home

Other conditions Intercostal neuralgia 16 mos
(Include pregnancy within 3 months of death)

MOTHER FATHER

11. Industry or business _____

12. Name Hugh M. Cahill

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

14. Maiden name Mary Jane Sullivan

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

Major findings: Of operations _____

Of autopsy _____

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

16. (a) Informant Mr. John J. Quinn

(b) Address 1331 Laurel

17. (a) Burial (b) Date thereof 12-7-44
(Burial, cremation, or removal) (City, town, or county) (State or foreign country)

(c) Place: burial or cremation Calvary Cem.

18. (a) Signature of funeral director Chas. J. Stuart

(b) Address 1225 Union Blvd

19. (a) DEC 6 1944 (b) J. F. Bradeck
(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) (e) Means of injury _____

23. Signature J. F. Gallagher M.D. (M-D. or other)
Address 3903 Olive Date signed 12/5/44

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

APR 11 1949

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 *John Gonoski*
.....
Licensed Embalmer No. *2398*
.....

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.