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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 29 1945
Registration District No. 317

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3487
Registrar's No. 2599

Primary Registration District No. 3063

1. PLACE OF DEATH:
(a) County St. Louis County
(b) City or town Clayton,
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis County Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 days (Specify whether
In this community 15 years. years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1510 Market Street
(If rural, give location)
(e) Citizen of foreign country? XX (Yes or No)
If yes, name country A

3. (a) PRINT Alexander McCabe
FULL NAME
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race white
6. (a) Single, widowed, married, divorced W
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 74 Months Days If less than one day
hr. min.

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

10. Usual occupation None

11. Industry or business None

MOTHER FATHER
12. Name ? McCabe
13. Birthplace ? ? (City, town, or county) (State or foreign country)
14. Maiden name ? ?
15. Birthplace ? ? (City, town, or county) (State or foreign country)

16. (a) Informant L W Evans
(b) Address 6304 Oakland Ave

17. (a) (b) Date thereof 12-14-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Louis County Hospital
18. (a) Signature of funeral director W. K. Miller

(b) Address 3500 Rutledge
19. (a) JAN 2 1945 (Date received local registrar) (b) E. J. McElharran (Registrar's signature) (c) M. D. (M. D. or other) (d) 601 Brentwood Blvd Clayton (Address) (e) 12/12 (Date signed)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 12 day 12
year 1944 hour 12:55 minute P.M.
21. I hereby certify that I attended the deceased from 12
7 19 44 12-12 19 44
that I last saw him alive on 12-12-1944
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration
Due to Arteriosclerosis
Due to _____

Other conditions Carcinoma of Prostate
(Include pregnancy within 3 months of death)
Major findings:
Of operations 51
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?
While at work? (Specify type of place) (e) Means of injury 0
Signature Moms. Allen (M. D. or other)
Address 601 Brentwood Blvd Clayton Date signed 12/12

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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.