

S. No. 2
M-5-43
5-17-39
I X35671

FILED MAR 9 1945
Registration District No. **818**

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:
5867 Nina Place
(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)

3. (a) PRINT FULL NAME Margaret E McKenna

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

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Joseph McKenna 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept. 14 1878
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>66</u>	<u>5</u>	<u>5</u>	hr. _____ min. _____

9. Birthplace St. Louis MO. 6
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business

12. Name Edward Flynn

13. Birthplace Ireland 4
(City, town, or county) (State or foreign country)

14. Maiden name Ellen Gallagher

15. Birthplace Ireland 4
(City, town, or county) (State or foreign country)

16. (a) Informant Catherine McKenna

(b) Address 5867 Nina Place

17. (a) Burial (b) Date thereof 2-21-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Arthur J. Donnelly

(b) Address 3840 Lindell Blvd. S.

19. (a) FEB 20 1945 (b) J. F. Bredee
(Date received local registrar) (Registrar's signature)

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. 5867 Nina Place
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 19
year 1945 hour 5 minute 30 A. M.

21. I hereby certify that I attended the deceased from 8-17-43 to Feb 19 1945
only one visit

that I last saw him alive on Feb 19 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of Stomach

Due to metastasis

Other conditions H6
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

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)

(c) Means of injury car

23. Signature Dr. M. D. Miller (M. D. or other)

Address 819 W. Chubbly Date signed 2-20-45

Mr. Clark
Mr. Clark
Ta 4300

Dr. J. L. ...
Dr. Pralle
Community Coll. Bldg.
11255

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 *W. Van Matre*
Licensed Embalmer No. *2825*
P. O. Address *4340 Lafayette*

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.