S. No. 2
M—5-42
v. 5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 27 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 11506

Registration District No. 818 Primary Registration District No. 1003 Registrar's No. 3414

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:
1510 McCausland 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:

000

(a) State Mo. (b) County 174

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

(d) Street No. 1510 McCausland Ave.,
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Micheal A. McCabe.

3. (b) If veteran, name war Mo

3. (c) Social Security 488-18-5269.

4. Sex Male B

5. Color or race White

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

6. (b) Name of husband or wife Harriet McCabe

6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased March 25, 1890.
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	55	0	21	hr. min.

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

10. Usual occupation Contractor retired

11. Industry or business

FATHER
12. Name James McCabe
13. Birthplace Ireland
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Catherine Costello
15. Birthplace Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Harriet McCabe
(b) Address 1510 McCausland Ave.,

17. (a) Burial (b) Date thereof April 18/45.
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cem.,

18. (a) Signature of funeral director Jos. W. Clark
(b) Address 1125 Hodiamont Ave.,

19. (a) APR 17 1945 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 15
year 1945 hour 6.30 minute A.M. M.

21. I hereby certify that I attended the deceased from 12/21, 1944, to 1/3, 1945;
that I last saw him alive on 1/3, 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Coronary Thrombosis	12/21/44
Due to	4/15/45
Due to	
Other conditions (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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature R. J. Willmon (M. D. or other) MD

Address 53 W. Big Bend Date signed 4/16/45

(Licensed Embalmer's Statement on Reverse Side)

Dr. C.J.Vollmer
55 W. Big bend Ave.
WE. 2203.
1-4 P.M.

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. 3225

P. O. Address 1125 Hodiamont Ave.,

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.