

UNITED STATES BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **15353**
Registrar's No. **4262**

FILED MAY 26 1945 18

Registration District No. _____ Primary Registration District No. **1003**

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:
1461a Goodfellow 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

3. (a) PRINT FULL NAME **Mary E. McBreen**

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

4. Sex **F.** 5. Color or race **W.** 6. (a) Single, widowed, married, divorced **M.**
6. (b) Name of husband or wife **John J. McBreen** 6. (c) Age of husband or wife if alive **73** years
7. Birth date of deceased **May 2nd., 1870**
(Month) (Day) (Year)

8. AGE: Years **75** Months **0** Days **11** If less than one day _____ hr. _____ min.

9. Birthplace **St. Louis** **Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **John Cashell**

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

14. Maiden name **Mary Reilly**

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

16. (a) Informant **Mr. John J. McBreen**

(b) Address **1461a Goodfellow Ave.**

17. (a) **Burial** (b) Date thereof **5-16-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Galvary**

18. (a) Signature of funeral director **Arthur J. Hennells**

(b) Address **3840 Lindell Blvd**

19. (a) **MAY 14 1945** (b) **J. F. Brodeur**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **1461a Goodfellow Ave.**
(If rural, give location)
(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **13th.**,
year **1945** hour **11** minute **30** a. M.

21. I hereby certify that I attended the deceased from **May 11**, 19**45**, to **May 13**, 19**45**;
that I last saw her alive on **May 10**, 19**45**;
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Thrombosis**
Due to **Arteriosclerosis**

Due to **Hypertension**

Other conditions **None**
(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)

23. Signature **Thomas Greener** (M. D. or other)
Address **4500 Olive St** Date signed **5/14/45**

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

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

00
17
9

Dr. Theo. Greiner
Lister Bldg. 1-4 pm.
leave and pick up later

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 H 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.