

U. S. No. 2
FORM-5-43
Rev. 5-17-39
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15360

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED MAY 21 1945
818

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Registration District No. _____ Primary Registration District No. _____

Registrar's No. 4121

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

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:
St. John's Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 10 Days
(Specify whether

In this community _____
 years, months or days)

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. Terminal Hotel (Union Station)
(If rural, give location)
 (e) Citizen of foreign country? 0 (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Hannah McGrath
 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 Phillip McGrath 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Aug. 25, 1864
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
80 8 11 hr. _____ min.

9. Birthplace St. Louis Mo. 11
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER {
 12. Name Charles Maley Ireland 4
 13. Birthplace Margaret Casey Ireland 4
(City, town, or county) (State or foreign country)
 14. Maiden name Ireland 4
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Ella Willis
 (b) Address 912 North Taylor Ave.

17. (a) Burial (b) Date thereof 5-11-45
(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 Lyndell Blvd

19. (a) MAY 9 1945 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 6,
 year 1945 hour 8 minute 45 P.A.M.

21. I hereby certify that I attended the deceased from July 33, to 5-6-1945
 that I last saw her ex alive on 5-6-1945
 and that death occurred on the date and hour stated above.

Immediate cause of death _____
Myocardial infarction
 Due to arterio-sclerotic coronary thrombosis
 Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN _____
 Major findings: _____
 Of operations _____
 Of autopsy _____
 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 _____
 23. Signature Arthur J. Donnelly (M. D. or other) _____
 Address 3840 Lyndell Blvd Date signed 5-8-45

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 Stanley Marshall
Licensed Embalmer No. 2868
P. O. Address 3840 Lindell

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.