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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

FILED AUG 11 1945 STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 818

Primary Registration District No. 1003

Registrar's No. 6819

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:
4061 Maffitt Ave. /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community 80 Years
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 000
(c) City or town St. Louis.
(If outside city or town limits, write "RURAL.")
(d) Street No. 4061 Maffitt Ave.
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Peter J. McCauley.

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

4. Sex M. 5. Color or race W. 6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife Margaret McCauley. 6. (c) Age of husband or wife if alive years

7. Birth date of deceased November 19, 1860
(Month) (Day) (Year)

8. AGE: Years Months 72 If less than one day
84 8 hr. min.

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

10. Usual occupation Retired.

11. Industry or business Railroad Terminal.

12. Name Matt. McCauley.

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

14. Maiden name Mary Shrylock.

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

16. (a) Informant Mrs. Kathryn Heil.

(b) Address 4061 Maffitt Ave.

17. (a) Burial (b) Date thereof 8-4-45
(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 Kinross Blvd

19. (a) AUG 3 1945 (b) J. F. Beede
(Date of local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 1,
year 1945 hour 11 minute 40 P.M.

21. I hereby certify that I attended the deceased from 8-1-45 to 8-1-45
that I last saw him alive on 8-1-45
and that death occurred on the date and hour stated above.

Immediate cause of death Uremia

Due to Chronic Nephritis

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 131

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) (e) Means of injury 0

23. Signature John J. Kehoe (M. D. or other)
Address 14145 St. Louis Date signed 8/2/45

Duration 1 wk
PHYSICIAN
Underline the cause to which death should be charged statistically.

*Dr. Kellogg
4143 St. Francis Ave
3-4*

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 Luedell*

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.