

S. No. 2  
OM-5-43  
v. 5-17-39  
I X36671

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

32130

State File No.

FILED NOV 10 1945  
Registration District No. 318

Primary Registration District No. 1005

Registrar's No. 9537

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
 (b) City or town St. Louis, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
St. Louis City Hospital-Max C. Starkloff  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 2 days Memorial  
(Specify whether  
 In this community 26 years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
 (c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 3535 Page Ave.  
(If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME JAMES MCCANN  
 3. (b) If veteran, name war Unk  
 3. (c) Social Security No. Unk

4. Sex male ( ) 5. Color or race white  
 6. (a) Single, widowed, married, divorced single ( )  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased August 8th-?  
(Month) (Day) (Year)

8. AGE: abt - 79 Years Months Days If less than one day  
 hr. min.

9. Birthplace Mass. (City, town, or county) (State or foreign country)  
 10. Usual occupation Unk

11. Industry or business \_\_\_\_\_  
 12. Name Patrick  
 13. Birthplace Unk (City, town, or county) (State or foreign country)  
 14. Maiden name Mary Unk  
 15. Birthplace Unk (City, town, or county) (State or foreign country)

16. (a) Informant M. Renard  
 (b) Address St. Louis City Hospital  
 17. (a) DURIAL (Burial, cremation, or removal) (b) Date thereof Nov 5- 1945  
(Month) (Day) (Year)  
 (c) Place: burial or cremation QUAVARY

18. (a) Signature of funeral director C. J. Kelly  
 (b) Address 4286 Lindell  
 19. (a) NOV 4 1945 (Date received local registrar) (b) J. F. Bresch (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 29th  
 year 1945 hour 10:50 minute \_\_\_\_\_ P. M.  
 21. I hereby certify that I attended the deceased from 10/27/45  
 19\_\_\_\_ to 10/29/45 19\_\_\_\_  
 that I last saw h. im alive on 10/29/45 19\_\_\_\_  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death Pneumony Tuberculosis  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions (Include pregnancy within 3 months of death) 13  
 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) (c) Means of injury \_\_\_\_\_  
 23. Signature Herbert C. Fry (M. D. or other) \_\_\_\_\_  
 Address 1515 Lafayette 10/30/45 signed \_\_\_\_\_

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

MOTHER FATHER

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

**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.....

*James R. Lammers*

Licensed Embalmer No.....

*4142*

P. O. Address.....

**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.**