

Registration District No. **318** Primary Registration District No. **1003**

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17
219
WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
5722 Cote Brilliante 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 McLaughlin

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female / 5. Color or race White

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

6. (b) Name of husband or wife Michael

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

7. Birth date of deceased March 10 1862
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>83</u>	<u>7</u>	<u>21</u>	_____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name John O'Neill

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

14. Maiden name Unk. Durkin

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

16. (a) Informant Kathryn McLaughlin

(b) Address 5722 Cote Brilliante

17. (a) Burial (b) Date thereof 11-5-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4790 Washington Blvd.

19. (a) NOV 2 1945 (b) J. H. Medesh
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

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

(d) Street No. 5722 Cote Brilliante
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)?
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 1
year 1945 hour 7 minute 00 A.M.

21. I hereby certify that I attended the deceased from June, 1934, to Nov 1, 1945,
that I last saw her alive on Nov 1 - 45, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Myocarditis

Due to _____

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? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature W. S. Brown (M. D. or other)
Address 3903 Olive Date signed 11/45

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..... *W. Wilkinson*.....

Licensed Embalmer No..... *3575*.....

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.