

U. S. No. 2
100M-5-43
Rev. 5-17-39
1 X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
STANDARD CERTIFICATE OF DEATH

32152
8961

State File No. _____
Registrar's No. _____

FILED OCT 25 1945
318

Registration District No. _____ Primary Registration District No. 1003

100
17
9

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:
3225 No. Florissant Ave. /
(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 43 Years.
years, months or days

3. (a) PRINT FULL NAME Peter McParland

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

4. Sex M. 5. Color or race W.

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: January 20, 1873
(Month) (Day) (Year)

8 / AGE: Years 72 Months 8 Days 26 If less than one day _____ hr. _____ min.

9. Birthplace England. 4
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

MOTHER FATHER

11. Industry or business _____

12. Name Michael McParland. 4

13. Birthplace Ireland. 4
(City, town, or county) (State or foreign country)

14. Maiden name Anne Miller.

15. Birthplace England. 4
(City, town, or county) (State or foreign country)

16. (a) Informant Sister Juanna

(b) Address 3225 N. Florissant

17. (a) Burial (b) Date thereof 10-17-45
(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 3849 Franklin Blvd

19. (a) OCT 17 1945 (b) J. F. Brebeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 96

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

(d) Street No. 714 Kingland
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No) 1
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 16.
year 1945 hour 5 minute 0. M.

21. I hereby certify that I attended the deceased from October 10 1945 to October 16 1945
and that I last saw him alive on October 15 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis
Atherosclerosis Duration ???

Due to _____

Due to _____

Other conditions None
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: None

Of operations None

Of autopsy None

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) No

(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 Bernard H. Stolle (M. D. or other) 0
Address 2302 Salisbury St Date signed 10-16-45

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.