

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:
Jewish Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

In this community _____
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Eileen McCann

3. (b) If veteran, name war Nil

3. (c) Social Security No. Unknown

4. Sex Female **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 November 15 1897
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
47	11	29	_____ hr. _____ min.

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

10. Usual occupation Housekeeper

11. Industry or business

12. Name Barney McCann

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

14. Maiden name Nellie Murphy

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

16. (a) Informant Barney McCann

(b) Address 1155 North & South Rd.

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

(c) Place: burial or cremation Hannibal, Missouri

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

(b) Address 4700 Washington Blvd.

19. (a) NOV 14 1945 **(b)** _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Pulaski **999**

(c) City or town Mounds **11**
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location) **NR**

(e) Citizen of foreign country? _____ (Yes or No) **0**
If yes, name country _____ **2**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 13
year 1945 hour 11 minute 50 P.M.

21. I hereby certify that I attended the deceased from Sept. 17, 1945, to Nov. 13, 1945.
that I last saw her alive on Nov. 13, 1945.
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
<u>Anemia, dehydration, cardiac decompensation</u>	
Due to <u>Cancer of the cervix</u>	
Due to _____	
Other conditions _____ <small>(Include pregnancy within 3 months of death)</small>	

PHYSICIAN

Major findings:
Of operations _____

Of autopsy Melanotic carcinoma of lungs, liver. Primary carcinoma of cervix

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)**

23. Signature Charles Wolfson (Internist) **(M. D. or other)**

Address Jewish Hospital **Date signed** 11-18-45

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

John Agnoski

Licensed Embalmer No. *3398*

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.

p. 2B
25-41
X27852

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 318

Primary Registration District No. _____

Registrar's No. 9880

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: _____
(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 Eileen McCann

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

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year

7. Birth date of deceased Nov - 15 - 1897
(Month) (Day) (Year)

8. AGE: Years 47 Months 11 Days 29 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) NOV 27 1948 (b) J. F. Bredack
(Date recorded by local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 13
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

35570