V. S. No. 2
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Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 19 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

1003

State File No. 35586

Registration District No. 318

Primary Registration District No.

Registrar's No. 9596

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: St.John's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1-week (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St.Louis

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

(d) Street No. 1123 Brightling Dr.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Mary B.McGrievy

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 W.

6. (b) Name of husband or wife Patrick McGrievy

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

7. Birth date of deceased May 22nd., 1863
(Month) (Day) (Year)

8. AGE: Years 82 Months 5 Days 12 If less than one day hr. min.

9. Birthplace St.Louis (City, town, or county) Mo. (State or foreign country)

10. Usual occupation At Home

11. Industry or business

FATHER
12. Name Bernard J.Higgins
13. Birthplace St.Louis (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name Mary Cooney
15. Birthplace Ireland (City, town, or county) (State or foreign country)

16. (a) Informant Miss Gene McGrievy
(b) Address 1123 Brightling Dr.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-7-45 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Arthur J. Donnelly
(b) Address 3840 Lindell Blvd.

19. (a) NOV 6 1945 (Date received by local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 4th., year 1945 hour 10 minute a. M.

21. I hereby certify that I attended the deceased from Oct. 27, 1945, to Nov 4, 1945 that I last saw h. alive on 10-3-1945 and that death occurred on the date and hour stated above.

Immediate cause of death Intertrochanteric fracture

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

Duration

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) Accident

(b) Date of occurrence Oct 27-45

(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? (Specify type of place)

While at work? (e) Means of injury Fall

23. Signature (M.D. or other) M.D.

Address Date signed 11-5-45

(Licensed Embalmer's Statement on Reverse Side)

Dr. George Gafney
Mo. The. Bldg. / NE. 5234

5-64

1-2

JAN 23 1946

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.