

S. No. 2
 DOM-2-43
 ev. 5-17-39
 X 35897

35890

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

FILED NOV 29 1945 STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **10080**

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:
3811 Maffit Ave
(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 **10 yrs.**

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo** (b) County **000**
 (c) City or town **38 St. Louis Ave**
(If outside city or town limits, write "RURAL")
 (d) Street No. **3811 Maffit Ave**
(If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No) **0**
 If yes, name country _____

3. (a) PRINT FULL NAME **Mary Josephine Stewart**
 3. (b) If veteran, name war **None**
 3. (c) Social Security No. **None**

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **Nov** day **20th.**
 year **1945** hour **12:10 P.** M. **M**

4. Sex **Female** 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **Widowed**
 6. (b) Name of husband or wife **Pierce L**
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **Feb 14th. 1877**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **10 - 23 - 1945** to **11 - 20 - 1945**
 that I last saw her alive on **11 - 19 - 1945**
 and that death occurred on the date and hour stated above.

8. AGE: Years **68** Months **9** Days **6**
 If less than one day hr. _____ min. _____

Immediate cause of death **Cerebral Apoplexy** Duration **27 Days**
 Due to **Hypertension** **1 yr**
 Due to **Chronic Intestinal Hepatitis** **1 yr**

9. Birthplace **Mo.** (City, town, or county) (State or foreign country)
 10. Usual occupation **Housewife**

Other conditions (include pregnancy within 3 months of death)

11. Industry or business **At Home**
 12. Name **? ?**
 13. Birthplace **?** (City, town, or county) (State or foreign country)
 14. Maiden name **Mary McCabe**
 15. Birthplace **Mo.** (City, town, or county) (State or foreign country)

PHYSICIAN
 Major findings:
 Of operations _____
 Of autopsy _____
 Underline the cause to which death should be charged statistically.

16. (a) Informant **Harry J Hatican**
 (b) Address **3811 Maffit Ave**

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? _____

17. (a) **Burial** (b) Date thereof **11/23/45**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Calvary Cent**

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

18. (a) Signature of **Harvigan & Sheahan Und Co.**
 (b) Address **4415 Washington Blvd.**
 19. (a) **NOV 21 1945** (b) **J. P. Bredeck**
(Date received local registrar) (Registrar's signature)

23. Signature **John J. Kehoe** (M. D. or other) _____
 Address **14145 St Louis** Date signed **11/20/45**

(Licensed Embalmer's Statement on Reverse Side)

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

20
17
9

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.