

S. No. 2  
OM-5-43  
v. 5-39  
36571

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **39000**

**FILED** DEC 28 1945  
Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **11094**

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

1. PLACE OF DEATH:  
(a) County St. Louis Mo.  
(b) City or town St. Louis Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
City Isolation Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 11-18-45-12-18-45  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME MARY CANTWELL  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. ?

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 Nov. 15 1880  
(Month) (Day) (Year)

8. AGE: Years 65 Months 1 Days 3  
If less than one day hr. min.

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

10. Usual occupation NIL

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name James Cantwell  
13. Birthplace Ireland (City, town, or county) (State or foreign country)  
14. Maiden name Mary Ann Cantwell  
15. Birthplace Ireland (City, town, or county) (State or foreign country)

16. (a) Informant City Inf records  
(b) Address 5500 Arsenal St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 17-20-45  
(Month) (Day) (Year)  
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director J. F. Bredeek  
(b) Address 2849 No. Euclid Ave

19. (a) DEC 19 1945 (Date received local registrar)  
J. F. Bredeek (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") 17  
(d) Street No. 5500 Arsenal 79  
4856 - 2nd St (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) 0  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Dec. day 18  
year 1945 hour 5 minute 00 a.m.  
21. I hereby certify that I attended the deceased from 10/18/45  
\_\_\_\_\_ 19 \_\_\_\_\_ to 12/18/45 19 45  
that I last saw her alive on 12/17/45 19 45  
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Duration 9 days  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions Generalized arterio-sclerosis, and senility  
(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)  
(c) Means of injury \_\_\_\_\_  
23. Signature John E. Hill (M. D. or other) M.D.  
Address 5600 Arsenal Date signed 12/18/45

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**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 Gyroski*

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.**