S. No. 2
DM—2-43
v. 5-17-39
b-1 X35697

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

10559

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED MAR 27 1946

State File No. 11647

Registration District No. 318 | Primary Registration District No. 1003 | Registrar's No. 2575

1. PLACE OF DEATH:

(a) County: St. Louis

(b) City or town: (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 3620 Cottage 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

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: 60W 17

(c) City or town: St. Louis (If outside city or town limits, write "RURAL") 11

(d) Street No. 3620 Cottage Ave. (If rural, give location) 0

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

If yes, name country

3. (a) PRINT FULL NAME: Mary Seward

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: Widowed

6. (b) Name of husband or wife:

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

7. Birth date of deceased: May (Month) 21st. (Day) 1874 (Year)

8. AGE: Years 71 | Months 9 | Days 24 | If less than one day: hr. min.

9. Birthplace: Missouri (City, town, or county) (State or foreign country) 0

10. Usual occupation: Housewife

11. Industry or business:

FATHER 12. Name: Mahan 4

13. Birthplace: Ireland (City, town, or county) (State or foreign country) 1

MOTHER 14. Maiden name: Unknown

15. Birthplace: Ireland (City, town, or county) (State or foreign country) 1

16. (a) Informant: Mr. Arthur Seward

(b) Address: 2863 Arlington Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 3/18/46 (Month) (Day) (Year)

(c) Place: burial or cremation: Memorial Park Cem

18. (a) Signature of funeral director: Sullivan Funeral Dir

(b) Address: 2849 No. Euclid Ave.

19. (a) MAR 18 1946 (Date received local registrar) (b) J. F. Bridek (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 15th. year 1946 hour 5.45 minute P.M.

21. I hereby certify that I attended the deceased from Feb 21-46, 19..., to March 15, 1946, that I last saw he alive on March 14, 1946, and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma of stomach

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):

(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? (Specify type of place)

While at work? (e) Means of injury: 0

23. Signature: D. A. Thomson (M. D. or other)

Address: 3121 N Grand Date signed: 2/16/46

(Licensed Embalmer's Statement on Reverse Side)

Dr. D. A. Thomson

3I2I North Grand Ave.

FR. I244

9 [illegible] 2-3 PM

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 Robert L. Brinkman

Licensed Embalmer No. 3553

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.