

S. No. 2
M-5-43
7. 5-17-39
I X36671

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

1548

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

State File No. 18670
Registrar's No. 4904

Registration District No. 318 Primary Registration District No. 1003

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:
De Paul Hospital
(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 Mary Grace Mc. Duffie
3. (b) If veteran, name war. No 3. (c) Social Security No. None

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 May 4 1946
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 0 27 hr. min.

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

10. Usual occupation Nil

11. Industry or business.....

MOTHER FATHER { 12. Name Robert Mc. Duffie
13. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Grace Eichenauer
15. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Robert Mc. Duffie
(b) Address 2811 Dodier St.

17. (a) Burial (b) Date thereof 6- 1- 46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Cullinane Bros.
(b) Address 1710 N. Grand Blvd.

19. (a) JUN 1 1946 J. B. B...
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 2811 Dodier St.
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 31
year 1946 hour 6 minute 30 P.M.

21. I hereby certify that I attended the deceased from
May 4 1946 to May 31 1946
that I last saw him alive on May 31 1946
and that death occurred on the date and hour stated above
Immediate cause of death malnutrition Duration
27 days

Due to congenital debility 27 days

Due to 158

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings: No operation
Of operations.....
Of autopsy None present
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 R. B. B... (M. D. or other)
Address 1117 N. Grand Date signed June 1/46

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.

Not Embalmed

Signed

Fred Frick

Licensed Embalmer No.....**3186**.....

P. O. Address **St. Louis, Mo.**.....

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.