

FILED AUG 5 1946
318

State File No. _____
Registrar's No. **6533**

Registration District No. _____ 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:
650 Tower Grove
(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 C. Mc Carthy
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 divorced

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

7. Birth date of deceased Aug. 21 1884
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
62 11 3 hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Mathew Mc Carthy
13. Birthplace Ireland (City, town, or county) (State or foreign country)
14. Maiden name Mary Burk
15. Birthplace St. Louis (City, town, or county) (State or foreign country)

16. (a) Informant Edward Mc Carthy
(b) Address 650 Tower Grove

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 27, 1946 (Month) (Day) (Year)

(c) Place: burial or cremation New St. Peter + Paul

18. (a) Signature of funeral director Jay B. Smith

(b) Address 7456 Manchester Ave

19. (a) III 25 1946 (Date received local registrar) (b) J. F. Pradeak (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. 650 Tower Grove (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No) 9
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 24
year 1946 hour 9 minute A M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death: Myocardial failure Thromb Metastatic Carcinoma 6 mm of liver - bones Abn. dilatation of heart 6 mm Carcinoma of breast 7 yrs
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Duration

3 days
6 mm
6 mm
7 yrs

Major findings: **ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**
Of operation _____
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) (e) Means of injury _____

23. Signature J. F. Pradeak (No D. or other) _____
Address 420 Maryland Date signed 7/27/46

4952 Maryland
11:30 A.M.

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.....

David B. Gibson

Licensed Embalmer No.

3454

P. O. Address.....

Maplewood

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Aug
Registrar's No. 6535

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:

(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 Mc Carthy

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 div

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

7. Birth date of deceased Aug 21 1884
(Month) (Day) (Year)

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

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

10. Usual occupation

11. Industry or business.....

MOTHER { 12. Name.....
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name.....
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant.....
(b) Address.....

17. (a) (Burial, cremation, or removal) (b) Date thereof Y
(Month) (Day) (Year)
(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....
(b) Address.....

19. (a) 7-25-46 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug
year 1946 minute M.

21. I hereby certify that I attended the deceased from 19.....
to 19.....
that I last saw h..... alive on 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death.....

Duration

Due to.....
Due to Carcinoma Pt Breast 7 YRS
Other conditions.....
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations..... 50
Of autopsy.....
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 S.H. PRANGER (M. D. or other)
Address 495 MARYLAND Date signed

SUPPLEMENTARY

MOTHER {

24930

25483