

S. No. 2
M-8-43
5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34649
State File No. _____
Registrar's No. 3165

FILED OCT 30 1946

Registration District No. _____ Primary Registration District No. 3066

Dr. Surgeon, Notify in Charge
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Kirkwood
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
U.S. Marine Hospital, Kirkwood, Mo
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 41 days
(Specify whether
In this community unknown
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Oklahoma (b) County 999
(c) City or town Alva
(If outside city or town limits, write "RURAL") 34
(d) Street No. 120 Center
(If rural, give location) 0
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME CARL THEODORE McDERMED

3. (b) If veteran, name war _____ 3. (c) Social Security No. 459-26-3369

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced single
6. (b) Name of husband or wife X 6. (c) Age of husband or wife if alive X years
7. Birth date of deceased June 16, 1888
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
58 4 9
hr. min.

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

10. Usual occupation Fireman

11. Industry or business Str. Huck Finn, St. Louis, Mo

MOTHER FATHER
12. Name JOHN W. McDERMED
13. Birthplace Illinois
(City, town, or county) (State or foreign country)
14. Maiden name MARGARET HARMON
15. Birthplace KENTUCKY
(City, town, or county) (State or foreign country)

16. (a) Informant Clinical Records of Hospital
(b) Address U.S. Marine Hospital, Kirkwood, Mo
17. (a) Burial (b) Date thereof 10/26/46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Oak Grove Cemetery

18. (a) Signature of funeral director Robert J. Ambruster Inc
(b) Address 6633 Clayton Road
19. (a) 10-28-46 (b) David S. Citron
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 25th
year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to 10/25/46, 19____;
that I last saw him alive on 10/25/46, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death: Congestive heart failure Duration 10 yrs
Due to Arteriosclerotic heart disease 10 yrs.

Due to 93d
Other conditions Right Inguinal Indirect Hernia Indef.

Major findings:
Of operations None
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) X
(b) Date of occurrence X
(c) Where did injury occur? X (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? X
(Specify type of place)
While at work? X Means of injury X
23. Signature David S. Citron (M. D. or other)
Address U.S. Marine Hospital, Kirkwood, Mo 10/25/46

OCT 30 1946

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 Arnold W. Schoene
Licensed Embalmer No. 3864
P. O. Address Harris 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.