

No. 2
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5-17-39
1 X47070

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **38847**
Registrar's No. **10153**

FILED DEC. 9 1946
18

Registration District No. _____
Primary Registration District No. **1003**

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

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 **0**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 14 Weeks
(Specify whether years, months or days)

In this community 60 Days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Jennie McAuliffe

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 Widowed

6. (b) Name of husband or wife John McAuliffe

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

7. Birth date of deceased Aug. 29th. 1865
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>81</u>	<u>2</u>	<u>27</u>	hr. _____ min.

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

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER

12. Name John Russell **4**

13. Birthplace England
(City, town, or county) (State or foreign country)

14. Maiden name Jennie Russell

15. Birthplace England **4**
(City, town, or county) (State or foreign country)

16. (a) Informant Joseph McAuliffe

(b) Address 4907 Davison Ave.

17. (a) Burial (b) Date thereof 11-29-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Arthur J. Donnell

(b) Address 1840 Linden Blvd

19. (a) NUV 27 1946 (b) J. F. Bredeco
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____

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

(d) Street No. 4907 Davison Ave
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 26
year 1946 hour 3. minute 35 A. M.

21. I hereby certify that I attended the deceased from Aug 4 1946 to Nov 25 1946
that I last saw her alive on Nov 20 1946
and that death occurred on the date and hour stated above.

Immediate cause of death myocardial infarction
acute **3 weeks**

Due to Hypertension **1860**

Due to _____ **18**

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

Es. Intertrichonem. Rt.

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) Accident

(b) Date of occurrence August 4, 1946

(c) Where did injury occur? Home
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? See Above

While at work? _____ (e). Means of injury Fall

23. Signature C. A. Stone M.D. (M. D. or other) **0**

Address 3720 Washington Date signed 11-27-46

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.

Signed Stanley Marshall
Licensed Embalmer No. 2868
P. O. Address 3840 Fundell

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.