

No. 2
12-45
-17-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 25 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

State File No. **38856**
Registrar's No. **9596**

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:
Alexian Brothers Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 Weeks**
In this community **60 Years**
(Specify whether years, months or days)

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. **3621 Gasconade St.**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **James J. McGlynn**
3. (b) If veteran, name war..... 3. (c) Social Security No.....

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **NOV.** day **9th.**
year **1946** hour **1** minute **15 A.M.**

4. Sex **M.** 5. Color or race **W.**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Mrs. Lizzie McGlynn**
6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased **July 12, 1863**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **10/22-46** to **Nov-8** 19**46**
that I last saw him alive on **Nov-8** 19**46**
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
83 **3** **27** hr. min.

Immediate cause of death **Cerebral Anemialage 2 wks**
Duration

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

Due to.....
Due to.....

10. Usual occupation **Police Department**

Other conditions (Include pregnancy within 3 months of death) **Senility 83**

11. Industry or business.....

Major findings: Of operations.....

12. Name **Thomas McGlynn**

Of autopsy.....
Underline the cause to which death should be charged statistically.

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

14. Maiden name **Margaret Farrell**

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

16. (a) Informant **Marie Byrne**

(b) Address **3621 Gasconade St.**

17. (a) **Burial** (b) Date thereof **11-12-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **Arthur J. Donnelly**

(b) Address **3840 Lindell Blvd**

19. (a) **NOV 11 1946** (b) **J. F. Brederick**
(Date received local registrar) (Registrar's signature)

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.....

25. Signature **J. F. Brederick** (M. D. or other).....

Address **406 S. 50th** Date signed **11/9/46**

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

4025-51
1-4
Gunn

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 Lindell

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.