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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 3 1947
Registration District No. 312

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3069

State File No. 3399-1244
Registrar's No. 11244

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

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town St. Louis Richmond / St
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Mary's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 1/2 months
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Michael Cuddy
3. (b) If veteran, name war no
3. (c) Social Security No. none

4. Sex male 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 August 12 1946
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
4 17 hr. min.

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

10. Usual occupation none

11. Industry or business none

12. Name Charles Cuddy
13. Birthplace Brookfield Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Fannie Mureno
15. Birthplace Poplar Bluff Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Charles Cuddy
(b) Address 6540 Dale avenue

17. (a) burial (b) Date thereof Dec-31-46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director A. Krow R. O. Co
(b) Address 2707 N. Grand Blvd

19. (a) DEC 31 1946 (b) Ruth Galloway
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 6-1
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 6540 Dale avenue
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 29
year 1946 hour 2 minute 30 a.m.
21. I hereby certify that I attended the deceased from Dec 6
1946 to Dec 29, 1946
that I last saw him alive on Dec 29, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death
myocardial infarction 10 hrs
atelectasis, pulmonary 10 hrs
congenital myeloid 4 mos
(birth)
Due to paralysis of RT mus
lum. leg. - flaccid birth
Other conditions
(Include pregnancy within 3 months of death)
157M

Duration
Underline the cause to which death should be charged statistically.

Major findings:
Of operations _____
Of autopsy _____

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 [Signature] (M. D. or other) MD
Address 4957 Maryland Date signed 12/31/46

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 H. Dixon*
Licensed Embalmer No. *4193*
P. O. Address *St. Louis*

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.