

No. 2-45
17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS

THE STATE BOARD OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

41958

State File No. _____

Registration District No. 317

Primary Registration District No. 6076

Registrar's No. 3466

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Normandy
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Our Lady of Good Counsel Home 5
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6-Months
(Specify whether years, months or days)

In this community 6-Months
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ill. (b) County 779

(c) City or town Decatur 11
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location) 2

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

3. (a) PRINT FULL NAME Mary E. Black

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 S. /

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

7. Birth date of deceased Jan. ?, 1875
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 8th., year 1946 hour 6 minute 30 P. M.

21. I hereby certify that I attended the deceased from Aug 6th, 1946 to Dec-5th, 1946 that I last saw her alive on Dec-5th, 1946 and that death occurred on the date and hour stated above.

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

<u>71</u>	<u>13</u>	<u>?</u>	hr. _____ min. _____
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Immediate cause of death

<u>Primary Cardiac Decompensation</u>	<u>4-Mo</u>
<u>Pulmonary Oedema</u>	<u>1-Mo</u>
<u>Due to Sec. Atrophic Spinal-Paralysis</u>	<u>1-Vr.</u>
<u>Due to Endo Carditis Chn Decompensation</u>	<u>?</u>

Other conditions (include pregnancy within 3 months of death) _____

9. Birthplace Decatur Ill. /
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business _____

12. Name John H. Black

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

14. Maiden name Mary McDonald
(City, town, or county) (State or foreign country)

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

16. (a) Informant Mr. John Black

(b) Address # 38 Aberdeen Place

17. (a) Removal (b) Date thereof 12-9-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Decatur, Ill.

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

(b) Address 3840 Lindell Blvd.

Major findings: Of operations _____

Of autopsy No.

Died in The Home of The Incurable.

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? _____

23. Signature Arthur J. Donnelly (Specify type of place) (e) Means of injury 11
(M. D. or other)

Address 3734 Jennings Rd. Date signed 12/9/1946

(Licensed Embalmer's Statement on Reverse Side)

WHILE MAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

JUN 15 1947

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 *W. Van Matre*

Licensed Embalmer No. *2825*

P. O. Address *4340 Lafayette*

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.