

Registration District No.

317

Primary Registration District No.

6076

Registrar's No.

3459

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:
17430 FLORISSANT
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)
 In this community _____
 years, months or days)

3. (a) PRINT FULL NAME MATHIAS M. D. MAGUIRE

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced MARRIED6. (b) Name of husband or wife ELALIA 6. (c) Age of husband or wife if7. Birth date of deceased Oct 31 1891
(Month) (Day) (Year)8. AGE: Years 55 Months 1 Days 5 If less than one day
_____ hr. _____ min.9. Birthplace St. Louis MO
(City, town, or county) (State or foreign country)10. Usual occupation CONTRACTOR11. Industry or business EXCAVATOR12. Name JAMES MAGUIRE 413. Birthplace IRELAND
(City, town, or county) (State or foreign country)14. Maiden name CATHERINE DOUGHERTY15. Birthplace St. Louis MO
(City, town, or county) (State or foreign country)16. (a) Informant Elalia Maguire(b) Address 7430 Florissant17. (a) BURIAL (b) Date thereof Dec 9 1946
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation CALVARY18. (a) Signature of funeral director Cullen Kelly(b) Address 7267 Nat Bridge19. (a) 12-9-46 (b) Russell J. Allen MD
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County St. Louis
 (c) City or town NORMANDY
 (If outside city or town limits, write "RURAL")
 (d) Street No. 7430 FLORISSANT
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 6
year 1946 hour 7 minute 30 A.M.21. I hereby certify that I attended the deceased from
Dec-6-1946, 1946 to Dec-6-46, 1946
that I last saw him alive on Dec-6-1946, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Coronary Thrombosis with Angina Pectoris 6 hours

Due to _____ 946

Due to Myocardial Angina Pectoris for past 8 months.Other conditions _____
(Include pregnancy within 3 months of death)

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) _____

(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 O. O. Smith M.D. (M. D. or other) _____Address 7430 Florissant Road Date signed 12/7/46

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 James G. Lemmers

Licensed Embalmer No. 4142

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.