

S. No. 2
DM-5-43
v. 5-17-39
I X36871

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 24 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **42231**
Registrar's No. **10595**

Registration District No. **318** Primary Registration District No. _____

41041
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County _____
(b) City or town **St. Louis Mo**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2838 Semple ave.
(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

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **2838 Semple ave.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Patrick Carbrey.**
3. (b) If veteran, name war **No.** **3. (c) Social Security** No. **No.**

4. Sex **Male** **5. Color or race** **W** **6. (a) Single, widowed, married, divorced** **Married**
6. (b) Name of husband or wife **Mary Hengesbach.** **6. (c) Age of husband or wife if alive** **70** years
7. Birth date of deceased **March 17 1871**
(Month) (Day) (Year)

8. AGE: **75** Years **8** Months **22** Days If less than one day
hr. _____ min.

9. Birthplace **Ireland** **4**
(City, town, or county) (State or foreign country)
Retired

10. Usual occupation _____

11. Industry or business _____

12. Name **Patrick Carbrey**

13. Birthplace **Ireland** **4**
(City, town, or county) (State or foreign country)

14. Maiden name **Sarah Rogers.**

15. Birthplace **Ireland** **1**
(City, town, or county) (State or foreign country)

16. (a) Informant **Wife Mary Carbrey**

(b) Address **2838 Semple ave.**

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director **Sullivan Bro's**
(b) Address **2849 N. Euclid ave.**

19. (a) DEC 10 1946 **(b) J. F. Bredenk**
(Date received and registered) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **9th**
year **1946** hour **1** minute **15** P. M.

21. I hereby certify that I attended the deceased from **12-9-46**
19 **12** to **12-9-46** 19 **46**
that I last saw him alive on **12-9-46**
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Coronary Thrombosis
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

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)
(c) Means of injury _____
23. Signature **Dr. A. H. Downing** (M. D. or other)
7347 28th Ave. St. Louis, Mo. Date signed **12/10/46**

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

Dr. Sewing.
2342 St. Louis ave.
Chestnut 2013

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.....

Robert J. Deakman

Licensed Embalmer No..... *3553*

P. O. Address.....

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.