

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **42311**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 23 1946
#10045

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **10754**

1. PLACE OF DEATH:
(a) County **St. Louis, Missouri.**
(b) City or town **St. Louis, Missouri.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **St. Louis City Hospital - Max C. Starkloff**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME **CATHERINE DEVANEY**

3. (b) If veteran, name war **NONE** **3. (c) Social Security No.** **NONE**

4. Sex **FEMALE** **5. Color or race** **W.** **6. (a) Single, widowed, married, divorced** **WIDOW**

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

7. Birth date of deceased **APRIL 7, 1869**
(Month) (Day) (Year)

8. AGE: Years **77** Months **8** Days **7** If less than one day _____ hr. _____ min.

9. Birthplace **ST LOUIS MO.**
(City, town, or county) (State or foreign country)

10. Usual occupation **NIL**

11. Industry or business _____

MOTHER { **12. Name** **PATRICK CARPENTER**

13. Birthplace **Ireland**

14. Maiden name **MARGARET COLMAN**

15. Birthplace **Ireland**

16. (a) Informant **Miss Catherine Lynch**

(b) Address **3772 DUNNICH**

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

(c) Place: burial or cremation **CALVARY COMM.**

18. (a) Signature of funeral director **E. J. SCHNUR**

(b) Address **3125 LAFAYETTE AVE.**

19. (a) DEC 16 1946 (Date received by registrar) **J. F. Breda** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **ST LOUIS MO** (b) County _____
(c) City or town **St Louis Mo** (If outside city or town limits, write "RURAL")
(d) Street No. **1821 W WARREN** Memorial (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 **14th** year **1946** hour **1:35** minute **P** M.

21. I hereby certify that I attended the deceased from **9/21/46**, 19____, to **Dec. 14th**, 19**46**
that I last saw h. **EX** alive on **Dec. 14th**, 19**46**
and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial Failure** Duration _____
57

Due to _____
Due to _____

Other conditions **Carcinoma of the urinary bladder**
(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? _____

(Specify type of place) _____
While at work? _____ (e) Means of injury _____
Signature **Jones & Cooney** **1515 Lafayette** **12/16/46** (Other) _____
Address _____ Date signed _____

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 Jon B. Volkmann
Licensed Embalmer No. 4014
P. O. Address St Louis Mo

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.