

No. 2  
12-45  
17-39  
X47070

FILED MAY 22 1947  
318

State File No. \_\_\_\_\_  
Registrar's No. 4822

Registration District No. \_\_\_\_\_ Primary Registration District No. 1003

1. PLACE OF DEATH:  
(a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Deaconess Hospital  
(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 Mo. (b) County 000  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1247 Clara Ave.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME William McFadden  
(b) If veteran, name war #1.  
(c) Social Security No. 334-09-1920

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month May day 12  
year 1947 hour 4.00 minute P.M.

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Geneveive McFadden  
6. (c) Age of husband or wife if alive 55 years  
7. Birth date of deceased Oct. 24, 1887  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Apr 17 to May 27  
that I last saw him alive on May 12, 1947  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
59 6 18 hr. min.

Immediate cause of death Cardiac failure  
Due to Hypertension  
Due to Falsing Partially  
Gastrocnomy  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

9. Birthplace Illinois  
(City, town, or county) (State or foreign country)  
10. Usual occupation Saleman Insurance  
11. Industry or business \_\_\_\_\_  
12. Name Milton McFadden  
13. Birthplace Illinois  
(City, town, or county) (State or foreign country)  
14. Maiden name Julia Scott  
15. Birthplace Denmark  
(City, town, or county) (State or foreign country)

Major findings: None of significance  
Of operations with many complex obstructions  
Of autopsy no

MOTHER FATHER

16. (a) Informant Mrs. Geneveive McFadden  
(b) Address 1247 Clara Ave.  
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 15/47  
(Month) (Day) (Year)  
(c) Place: burial or cremation Memorial Park Cem.  
18. (a) Signature of funeral director Jos. W. Clark  
(b) Address 1125 Hodiamont Ave.  
19. (a) MAY 13 1947 (Date received local registrar)  
(b) [Signature] (Agent of Registrar)

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 kind of place)  
(b) Means of injury \_\_\_\_\_  
23. Signature [Signature] (M. D. or other)  
Address 475 Locust Ave. Date signed 2/13/47

Duration  
1  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

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

Dr. Robert Mueller  
Arcade Bldg. Room 975,  
CE. 3847 1-5.30 P.M.

JUN 3 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

*Alfred J. Boedecker*

Licensed Embalmer No. 2663

P. O. Address 1125 Hodiamont Ave.,

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.