

0. 2
2-45
7-39
K47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 5 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 19203

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5264

1. PLACE OF DEATH:

(a) County...
(b) City or town... ST. LOUIS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
900 S. EWING
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether)
In this community (Specify whether)
years, months or days

3. (a) PRINT FULL NAME MARGARET OATES.

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

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife MICHAEL T. OATES 6. (c) Age of husband or wife if alive... years
7. Birth date of deceased OCTOBER 5 1872
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
74 7 20 hr. min.

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

10. Usual occupation HOUSEKEEPER

11. Industry or business OWN.

MOTHER FATHER

12. Name WILLIAM MAHER

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

14. Maiden name ANNA RYAN

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

16. (a) Informant Michael T. Oates

(b) Address 900 S. EWING AV.

17. (a) BURIAL (b) Date thereof MAY 28-47
(Burial, cremation, or other) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY CEM.

18. (a) Signature of funeral director E. J. Schner

(b) Address 3125 Lafayette Ave.

19. (a) MAY 27 1947 (Date received local registration)
J. F. Breard (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County ST. LOUIS
(c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")
(d) Street No. 900 S. EWING AV.
-22- (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 25
year 1947 hour 8 minute 30 P. M.

21. I hereby certify that I attended the deceased from FEB 2, 1947 to MAY 25, 1947
that I last saw him or her alive on MAY 25, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of stomach

Due to...
Due to... Cholecystitis

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations...
Of autopsy... H/O

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

22. If death was due to external causes, fill in the following:

(c) 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 Otto C. Hauser M.D. (M. D. or other)
Address 3612 Lafayette Date signed 5/29/47

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

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 *Joe B. Vollmer*
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.