

FILED AUG 15 1947
Registration District No.

Primary Registration District No. **1003**

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

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: **5055 Maple 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 **000**

(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")

(d) Street No. **5055 Maple Ave.**
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **James T. Cummiskey**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **489-09-5424**

4. Sex **Male** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Rose Alice Cummiskey**

6. (c) Age of husband or wife if alive **63** years

7. Birth date of deceased **September 16, 1883**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
63		10	19	
			hr.	min.

9. Birthplace **Bunker Hill Illinois**
(City, town, or county) (State or foreign country)

10. Usual occupation **Bookkeeper**

11. Industry or business **Crystal Mirror Co.**

12. Name **William Cummiskey**

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

14. Maiden name **Mary Anne Fleming Illinois**

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

16. (a) Informant **Mrs. Rose Alice Cumminkey**

(b) Address **5055 Maple Ave.**

17. (a) **Burial** (b) Date thereof **18-9-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **W. J. Stuart**

(b) Address **1225 Mission**

19. (a) **AUG 7 1947** (b) **J. F. Greath**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **5**
year **1947** hour **4** minute **40** P.M.

21. I hereby certify that I attended the deceased from **2/22** 19**47** to **8/5** 19**47**
that I last saw him alive on **8/4** 19**47**
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Myocarditis**

Due to **Arterio Sclerosis**

Other conditions **Heart exhaustion**
(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? _____ (Specify name of place)

While at work _____ Means of injury _____

23. Signature **W. J. Stuart** (M. D. or other) _____

Address **5203 Chaffin St** Date signed **8/7/47**

Duration

2/1947

plus

2/1947

8/4/1947

PHYSICIAN

Underline the cause of which death should be charged statistically.

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 _____

J. Allen Davis Jr.

Licensed Embalmer No. _____

4053

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.