

FILED AUG 4 1947
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State File No. _____
Registrar's No. 6953

Registration District No. _____ Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(c) Name of hospital or institution: 1406a Hebert St.
(d) Length of stay: In hospital or institution _____
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County San
(c) City or town St. Louis
(d) Street No. 1406a Hebert St
(e) If foreign born, how long in U. S. A. ? _____ years

3. (a) PRINT FULL NAME Thomas Michael Mc Coy

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced S

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

7. Birth date of deceased July 12, 1887
(Month) (Day) (Year)

8. AGE: Years 60 Months 0 Days 12 If less than one day hr. _____ min. _____

9. Birthplace St. Louis
(City, town, or county) (State or foreign country)

10. Usual occupation Clerk

11. Industry or business _____

MOTHER FATHER { 12. Name Thomas Michael Mc Coy
13. Birthplace Ireland
14. Maiden name Bridget Phelan
15. Birthplace Ireland

16. (a) Informant Mrs. Mary Begley
(b) Address 1406a Hebert St

17. (a) burial (b) Date thereof 7-28-1947
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Harrigan & Sheahan
(b) 4415 Washington Bl

19. (a) JUL 26 1947 (b) J. F. Bredash
(Date received from registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July - day 24
year 1947 hour 11 minute 52 A. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic endocarditis
Chronic interstitial
Due to Chronic interstitial
PENDING
Due to hypertension
Other conditions 12/1
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____
PHYSICIAN _____

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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place)
(e) Means of injury 3
23. Signature Walter J. O'Leary (M. D. or other)
Date signed 7/25/47

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

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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 *Henry W. Brammer*

Licensed Embalmer No. *4200*

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, above space should be left blank.