

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **27992**

Registration District No. \_\_\_\_\_

Primary Registration District No. **1003**

Registrar's No. **7745**

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: Enroute City Hospital 3  
(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)

3. (a) PRINT FULL NAME O'Dell McQuarry

3. (b) If veteran name war None 3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Aslene McQuarry 6. (c) Age of husband or wife if alive 27 years  
7. Birth date of deceased February 25 1905  
(Month) (Day) (Year)

8. AGE: Years 43 Months 6 Days 6 If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Lynchburg, Virginia  
(City, town, or county) (State or foreign country)

10. Usual occupation Owner

11. Industry or business Radio Cab Company

12. Name Frank E. McQuarry  
13. Birthplace Virginia  
(City, town, or county) (State or foreign country)  
14. Maiden name Laura Sanders  
15. Birthplace Virginia  
(City, town, or county) (State or foreign country)

16. (a) Informant Aslene McQuarry  
(b) Address Lynchburg, Virginia  
17. (a) Removal (b) Date thereof 9/1/48  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Lynchburg, Virginia  
18. (a) Signature of funeral director Albert H. Hoppe  
(b) Address 4700 Washington Blvd.  
19. (a) SEP 2 1948 (b) J. F. Bradeck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Virginia (b) County 999  
(c) City or town Lynchburg 44  
(If outside city or town limits, write "RURAL")  
(d) Street No. R. F. D. #4 0  
(If rural, give location) 2  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 31  
year 1948 hour 11:15 minute 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 Myocarditis, Duration  
decompensated.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(c) Means of injury \_\_\_\_\_  
23. Signature Dr. Alfred J. Perry 3 (M. D. or other) DDS  
Address Dr. Coroner Date signed 9/2/48

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

MOTHER FATHER

7245

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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 Robert M. Murray  
Licensed Embalmer No. 3749  
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.**