

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 31237
8281
Registrar's No. _____

FILED OCT 1 1948 318
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: DePaul Hospital
(If not in hospital or institution, write street number or location) 3-hours
(d) Length of stay: In hospital or institution 3-hours
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME James Wm. McNiff

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

4. Sex M. 5. Color or race W. 6. (a) Single, widowed, married, divorced M.
6. (b) Name of husband or wife Maud E. McNiff 6. (c) Age of husband or wife if alive 58 years
7. Birth date of deceased July 5th., 1885
(Month) (Day) (Year)

8. AGE: Years 63 Months 2 Days 14 If less than one day hr. _____ min. _____

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

10. Usual occupation Gas Fitter

11. Industry or business _____

12. Name Owen J. McNiff

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

14. Maiden name Marcella Howard

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

16. (a) Informant Mrs. Maud E. McNiff

(b) Address 4922 Alcott Ave.

17. (c) Burial (b) Date thereof 9-23-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Catholic Donnelly

18. (a) Signature of funeral director 3840 Lindell Blvd.

(b) Address _____

19. (a) SEP 22 1948 (b) J. F. Buesch
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County San
(c) City or town St. Louis
(If outside city or town limits, write "RURAL") 17
(d) Street No. 4922 Alcott Ave.
(If rural, give location) 5
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 19th.,
year 1948 hour 4 minute 15 p. M.

21. I hereby certify that I attended the deceased from June 15
1947 to Sept 19, 1948
that I last saw him alive on Sept 19, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic valvular heart disease

Due to _____
Due to 92

Other conditions chronic asthma
(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?

While at work _____ (Specify type of place)
(e) Means of injury 0

23. Signature R. R. Menoua (M. D. or other) MD

Address 5730 Lippoldine Date signed 9/21/48

Duration Don't know
PHYSICIAN Don't know
Underline the cause to which death should be charged statistically.

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

21

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 Stanley Marshall

.....
Licensed Embalmer No. 2868

P. O. Address 3840 Russell

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.