

3-300
10-47
7-39
3906

FILED DEC 14 1948
Registration District No. 318

Primary Registration District No. 1003

Registrar's No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Barnes Hospital, D
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 Hours
(Specify, whether years, months or days)

3: (a) PRINT FULL NAME MARY MATILDA MCMAHON

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

4. Sex F. / 5. Color or race W 6. (a) Single, widowed, married, divorced Widow

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

7. Birth date of deceased Dec 17 1873
(Month) (Day) (Year)

8. AGE: Years 75 Months 11 Days 13 If less than one day hr. min.

9. Birthplace Pilot Knob Mo. D
(City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business _____

12. Name Louise Reinhard

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

14. Maiden name Pauline Steg

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

16. (a) Informant Louise Mc Mahon

(b) Address Farmington Mo.

17. (a) Burial (b) Date thereof Dec 3/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Old Calvary Farmington Mo

18. (a) Signature of funeral director Organ Funeral Home

(b) Address Farmington Mo

19. (a) DEC 2 1948 (b) J. B. Gasater
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Francis
(c) City or town Farmington
(If outside city or town limits, write "RURAL")
(d) Street No. W.R. (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 30
year 1948 hour 5 minute A.M.

21. I hereby certify that I attended the deceased from Nov. 29
1948 to Nov. 30 1948,
that I last saw her alive on Nov. 30, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death acute (meningococcal) meningitis Duration 2 days

Due to Bacteremia: petechial over trunk, arms, legs.

Due to _____

Other conditions arteriosclerosis generalized
(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? _____

(Specify type of place)
While at work? _____ (2) Means of injury _____

23. Signature Joseph [unclear] (M. D. or other) MD

Address 312 1/2 Washington Blvd Date signed 11/22/48

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

MOTHER FATHER

10455

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 Jan M. Jensen

Licensed Embalmer No. 4343

P. O. Address At. Louis 10 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.