

S. No. 30
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WI 3906

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED NOV 30 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

38862 ✓
State File No. _____
Registrar's No. 2651

Registration District No. 317

Primary Registration District No. 3063

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

1. PLACE OF DEATH:

(a) County St. Louis County
(b) City or town CLAYTON
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis County Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 hours. (Specify whether WIFE)
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis Co.
(c) City or town JENNINGS
(If outside city or town limits, write "RURAL")
(d) Street No. 5744 ALBIA TERRACE
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

GEORGE McNAMARA

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex MALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife JOHANNA

6. (c) Age of husband or wife if alive 53 years

7. Birth date of deceased SEPT. 18 1893
(Month) (Day) (Year)

8. AGE: Years 65 Months 1 Days 26 If less than one day _____ hr. _____ min.

9. Birthplace FLORISSANT MO. U.
(City, town, or county) (State or foreign country)

10. Usual occupation MACHINIST

11. Industry or business BUCK X-GRAPH

12. Name PATRICK McNAMARA

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

14. Maiden name MARGARET ROSEN

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

16. (a) Informant St. Louis County Hospital

(b) Address CLAYTON, MO.

17. (a) Burial (b) Date thereof 11-19-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Ferdinand

18. (a) Signature of funeral director with name on

(b) Address 2166 E Fair

19. (a) 11-16-48 (b) Gene J. Shapiro
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 14
year 1948 hour 11:10 minute 7 P.M.

21. I hereby certify that I attended the deceased from Nov. 14, 1948 to Nov. 14, 1948

that I last saw him alive on Nov. 14, 1948 and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Cerebral hemorrhage + Brain damage

Due to Fall down steps and striking head.

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy pending

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) Accident

(b) Date of occurrence Nov. 14, 1948

(c) Where did injury occur? JENNINGS - St. Louis - MO.
(City or town) (County) (State)

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

While at work _____ (Specify type of place)
(e) Means of injury FELL DOWN STAIRS

23. Signature John Wm. [unclear] (M. D. or other) _____

Address 601 S. BRENTWOOD Date signed _____

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.....

Licensed Embalmer No.....

P. O. Address.....

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.

MISSOURI DIVISION OF HEALTH
 STANDARD CERTIFICATE OF DEATH

State File No. 25

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County St. Louis
 (b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Louis County Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 4 hours
(Specify whether
 In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
 (c) City or town Jennings
(If outside city or town limits, write "RURAL")
 (d) Street No. 5744 Albia Terrace
(If rural, give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3. (a) PRINT FULL NAME

George P. McNamara

3. (b) If veteran, name war None

3. (c) Social Security No. 486-18-5575

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 14th
 year 1948 hour 10:07 P.M. minute M.

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Johanne McNamara 6. (c) Age of husband or wife if alive 53 years
 7. Birth date of deceased September 18, 1883
(Month) (Day) (Year)

Immediate cause of death
 Due to
 Due to

8. AGE: Years Months Days If less than one day
65 1 27 hr. min.

Other conditions
(Include pregnancy within 3 months of death)

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

10. Usual occupation Machinist

11. Industry or business

Major findings:
 Of operations
 Of autopsy

12. Name Patrick McNamara
 13. Birthplace Unknown Ireland
(City, town, or county) (State or foreign country)
 14. Maiden name Margaret Rosch
 15. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:

16. (a) Informant Mrs. Hohama McNamara
 (b) Address 5744 Albia Terrace Jennings, Mo.

(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?

17. (a) Burial (b) Date thereof 11/18/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: Burial or cremation St. Ferdinand, Florissant, Mo.

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

18. (a) Signature of funeral director Math Hermann & Son, Inc.

(b) Address 2161 East Fair Ave

23. Signature (M. D. or other)

19. (a) (b)
(Date received local registrar) (Registrar's signature)

Address Date signed

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

MOTHER FATHER

DEC 1 1948

38862

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.....

.....
working under my personal supervision.

Registered Apprentice No.....
Signed *W. W. [Signature]*
Licensed Embalmer No. *2737*
P. O. Address *216.5 E. Fair Ave*

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.