

FILED JAN 29 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 2976
341

318

1003

Registrar's No.

BIRTH NO.		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No.			
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri				b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		12			
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Louis City Hospital #71				d. STREET ADDRESS (If rural, give location) 10 4036a Labadie				J	
3. NAME OF DECEASED (Type or Print)			a. (First) DENNIS		b. (Middle) McCUDDY		c. (Last)		
4. DATE OF DEATH		(Month) (Day) (Year)		Jan. 19th, 1949					
5. SEX Male (1)		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH April 24, 1864		9. AGE (In years last birthday) 84	
						IF UNDER 1 YEAR Months 8		IF UNDER 1 YEAR Days 16	
								IF UNDER 1 YEAR Hours	
								IF UNDER 1 YEAR Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer			10b. KIND OF BUSINESS OR INDUSTRY Foreman			11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13a. FATHER'S NAME Dennis McCuddy			13b. MOTHER'S MAIDEN NAME Bridget O'Leary			14. NAME OF HUSBAND OR WIFE Caroline McCuddy			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT'S SIGNATURE OR NAME Clarence L. McCuddy			ADDRESS 4036a Labadie		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>unknown</u>							
		ANTECEDENT CAUSES *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>generalized arterio sclerosis</u>						?	
		DUE TO (c) <u>97</u>						4500	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>arterial psychosis, simple arteriosclerosis</u>						1 1/2 yrs	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>12/29/48</u> , 19 <u>48</u> , to <u>1/10/49</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>1/10/49</u> , 19 <u>49</u> , and that death occurred at <u>10</u> m., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) Paul M. Caldwell M.D.				23b. ADDRESS 1515 Lafayette Ave.,			23c. DATE SIGNED 1/10/49		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Jan 13		24c. NAME OF CEMETERY OR CREMATORY Calvary		24d. LOCATION (City, town, or county) (State) St. Louis Mo			
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE JAN 12 1949		REGISTRAR'S SIGNATURE J. B. Fosater		FURNERAL DIRECTOR'S SIGNATURE Charles Stuart		ADDRESS 1225 Union			

(Licensed Embalmer's Statement on Reverse Side)

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

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.....

..... Student Embalmer No.

working under my personal supervision.

Signed..... *Ray W. Wilkinson*

Signed.....
Student Embalmer

Licensed Embalmer No. *3575*

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.