

FILED FEB 26 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6033

State File No. 1412

BIRTH NO. _____		REG. DIST. NO. 318	PRIMARY REG. DIST. 1003	Registrar's No. 1412
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 OR TOWN St. Louis) c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis 17 9		
d. FULL NAME OF HOSPITAL OR INSTITUTION 3633 Sullivan Ave.		d. STREET ADDRESS (If rural, give location) 3633 Sullivan Ave. 0		
3. NAME OF DECEASED (Type or Print) a. (First) Mary b. (Middle) A. c. (Last) Carmody			4. DATE OF DEATH (Month) (Day) (Year) Feb. 11th, 1949	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Aug. 15, 1887	9. AGE (In years last birthday) 61 IF UNDER 1 YEAR Months Days IF UNDER 2 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY?
13a. FATHER'S NAME John Meehan		13b. MOTHER'S MAIDEN NAME Margaret Stack	14. NAME OF HUSBAND OR WIFE John P. Carmody	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Jack Carmody ADDRESS 3633 Sullivan Ave.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Uterus ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. H8 174X		INTERVAL BETWEEN ONSET AND DEATH 6 Months
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)	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 Sept 5, 1947 to Feb 11, 1949 , that I last saw the deceased alive on Feb 11, 1949 , and that death occurred at 5:20 P.M. , from the causes and on the date stated above.				
23a. SIGNATURE (Degree or title) Dr. Wayne Garland		23b. ADDRESS 2739 N. Grand		23c. DATE SIGNED 2/14/49
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 2/15/49	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
DATE REC'D BY LOCAL REG. FEB 14 1949	REGISTRAR'S SIGNATURE J. B. Basater	25. FUNERAL DIRECTOR'S SIGNATURE Sullivan Funeral Dir. ADDRESS 2849 Euclid		

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

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Dr. Wayne Gorla
2739 North Grand Ave.
Ne. I270

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.

Student Embalmer No.

Signed.....
Student Embalmer

Signed

Robert L. Brinkman
3553

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.