

No. 300
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FILED MAR 8 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 6928

BIRTH NO. 49-011817 REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 3069 Registrar's No. 393

1. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO b. COUNTY 000	
b. CITY OR TOWN RICHMOND HGTS	c. LENGTH OF STAY (in this place)	c. CITY OR TOWN ST. LOUIS	17 9
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. MARY'S HOSPITAL		d. STREET ADDRESS (If rural, give location) 6917 FIELD AVE 1	

3. NAME OF DECEASED (Type or Print) JAMES RAYMOND McNAMEE			4. DATE OF DEATH (Month) (Day) (Year) FEB 18 1949	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) INFANT	8. DATE OF BIRTH FEB. 18-1949	9. AGE (In years last birthday) 5
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MO Richmond	
12. CITIZEN OF WHAT COUNTRY?				

13a. FATHER'S NAME JOHN R. McNAMEE	13b. MOTHER'S MAIDEN NAME DOROTHY FLYNN	14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME John R. McNamee ADDRESS 6917 Field Ave	

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) Congenital atelangiectasis	ANTECEDENT CAUSES		5 hrs
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	DUE TO (b) 9623		
	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS	Conditions contributing to the death but not related to the disease or condition causing death.		1670

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" 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) 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 **2-16**, 19**49**, to **2-16**, 19**49**, that I last saw the deceased alive on **2-16**, 19**49** and that death occurred at **5:58** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) [Signature] M.D.	23b. ADDRESS 4500 Olive	23c. DATE SIGNED 2-16-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE FEB 19-1949	24c. NAME OF CEMETERY OR CREMATORY CALVARY CEM	24d. LOCATION (City, town, or county) (State) ST. LOUIS, MO
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DATE REC'D BY LOCAL REG. 2-19-49	REGISTRAR'S SIGNATURE J. V. Linniger, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE H. MULLEN UND. ADDRESS 5165 DELMAR BL
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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 A J Jarvis

Signed _____
Student Embalmer

Licensed Embalmer No. 3384

P. O. Address J Jarvis

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.