

FILED AUG 5 1949

STANDARD CERTIFICATE OF DEATH

318

1003

State File No. 25069
6600

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission). a. STATE Mo. b. COUNTY gas	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN 17 St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1224 McCausland Ave		d. STREET ADDRESS (If rural, give location) 1224 McCausland Ave.	

3. NAME OF DECEASED (Type or Print) a. (First) Julia b. (Middle) C. c. (Last) McCarthy			4. DATE OF DEATH (Month) (Day) (Year) July 29, 1949		
5. SEX F.		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	
8. DATE OF BIRTH Mar. 12, 1878		9. AGE (In years last birthday) 71		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 4 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 Carl Kietz		13b. MOTHER'S MAIDEN NAME Augusta Stamer		14. NAME OF HUSBAND OR WIFE William H.S. McCarthy	
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.		17. INFORMANT'S SIGNATURE OR NAME John E. Deere	
				ADDRESS 4362 Shreve	

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) Chronic Myocarditis			INTERVAL BETWEEN ONSET AND DEATH 4 years	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) General Arteriosclerosis			4 years	
DUE TO (c)						
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						

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) 97		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 4500		

22. I hereby certify that I attended the deceased from **July 24, 1946**, to **July 29, 1949**, that I last saw the deceased alive on **July 1, 1949**, and that death occurred at **8:30 P. M.**, from the causes and on the date stated above.

23a. SIGNATURE St. Louis Bluechat, M.D. (1)		23b. ADDRESS 2200 Chouteau av		23c. DATE SIGNED 7-30-49	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 8-1-49		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
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DATE REC'D BY LOCAL REG. JUL 31 1949		REGISTRAR'S SIGNATURE J. B. Lacoste		25. FUNERAL DIRECTOR'S SIGNATURE Arthur J. Donnelly		ADDRESS 3840 Audell	
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2200 (Kearney Ave)
1-530 W

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.

Student
Student Embalmer

Signed

Thomas R. Fenwick

Licensed Embalmer No. 3793

P. O. Address 3840 Lindell

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.