

FILED AUG 5 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25071

318

1003

State File No.

6342

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 Missouri b. COUNTY	
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 St. Louis	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Johns Hospital		4951 Parkview	

3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) Joseph c. (Last) McCauley			4. DATE OF DEATH (Month) (Day) (Year) July 20 1949		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	
8. DATE OF BIRTH Aug. 24, 1885		9. AGE (In years last birthday) 63		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Orderly		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Mitchie, Ill.	
12. CITIZEN OF WHAT COUNTRY? U.S.					

13a. FATHER'S NAME Lawrence McCauley		13b. MOTHER'S MAIDEN NAME Rachel Widson		14. NAME OF HUSBAND OR WIFE None	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT'S SIGNATURE OR NAME Cora McCormick, Vallmeyer, Ill. ADDRESS	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Nephritis, chronic			INTERVAL BETWEEN ONSET AND DEATH 2 yrs
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid 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. Arteriosclerotic heart dis.			Unk.

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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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) 93	
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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? H 200	
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22. I hereby certify that I attended the deceased from **April 1946** to **July 20, 1949**, that I last saw the deceased alive on **July 20, 1949**, and that death occurred at **3:00 pm.**, from the causes and on the date stated above.

23a. SIGNATURE W.C. Missett, Jr. (Degree or title) M.D.		23b. ADDRESS 634 No. Grand		23c. DATE SIGNED 7/21/49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 7-21-49		24c. NAME OF CEMETERY OR CREMATORY Festus, Mo.	
24d. LOCATION (City, town, or county) (State)					

DATE REC'D BY LOCAL REG. JUL 21 1949		REGISTRAR'S SIGNATURE J.P. Lasater		25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe ADDRESS 4700 Washington Blvd.	
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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.

Student
Student Embalmer

Signed

J. Wm. Bumbley

Licensed Embalmer No. _____

3153

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.