

FILED OCT 28 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35362

State File No. _____
Registrar's No. 8972

318

1003

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|--|---------------------------|--|---|---|---|
| BIRTH NO. _____ | | REG. DIST. NO. _____ | | PRIMARY REG. DIST. NO. _____ | |
| 1. PLACE OF DEATH a. COUNTY _____ | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>St. Louis</u> | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis Mo.</u> | | c. LENGTH OF STAY (in this place) <u>8/26/49</u> | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u> | | 17 |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>De Paul Hosp.</u> | | | d. STREET ADDRESS (If rural, give location) <u>4222 Cleveland</u> | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>Mary E.</u> | | b. (Middle) <u>Warrington</u> | | c. (Last) <u>MacNichols</u> | 4. DATE OF DEATH (Month) (Day) (Year) <u>Oct 15 1949</u> |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOW</u> | 8. DATE OF BIRTH <u>Nov. 24 11874</u> | 9. AGE (In years last birthday) <u>75</u> | IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 4 HRS. Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>*****</u> | 11. BIRTHPLACE (State or foreign country) <u>Peachville Penn.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13a. FATHER'S NAME <u>Geo. Warrington</u> | | 13b. MOTHER'S MAIDEN NAME <u>Emma Gilroy</u> | | 14. NAME OF HUSBAND OR WIFE <u>Charles E. Macnichols</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____ | | 16. SOCIAL SECURITY NO. <u>*****NO</u> | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>A. G. MacNichols 6158 Simpson</u> | | |
| 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, asthma, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>myocarditis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>nephritis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Fracture Femoral neck Rt.</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>?</u> <u>89040</u> <u>21</u> |
| 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) <u>accident</u> | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u> | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>St. Louis Co. Mo</u> | | |
| 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? <u>This is not known. Probably a month before entering Hosp.</u> | | |
| 22. I hereby certify that I attended the deceased from <u>Aug 26, 1949</u> , to <u>Oct 15, 1949</u> , that I last saw the deceased alive on <u>Oct 15, 1949</u> , and that death occurred at <u>10:15 P.M.</u> , from the causes and on the date stated above. | | | | | |
| 23a. SIGNATURE (Degree or title) <u>C. A. Stone M.D.</u> | | | 23b. ADDRESS <u>3720 Washington</u> | | 23c. DATE SIGNED <u>10-17-49</u> |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> | | 24b. DATE <u>Oct 19 1949</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Crematory</u> | 24d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Mo.</u> | |
| DATE REC'D BY LOCAL REG. <u>OCT 18 1949</u> | | REGISTRAR'S SIGNATURE <u>J. B. Basater</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Alexander & Son 6175 Delmar</u> | |

(Licensed Embalmer's Statement on Reverse Side)

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

Dr Charles Stone
Beaumont Bldg
Je 6505

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

Jos. E. McCulloch

Licensed Embalmer No. *2768*

P. O. Address

6125 Delmar

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.