

FILED MAY 10 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14827

State File No. _____

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **4010**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis	c. LENGTH OF STAY (In this place) township)	c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4109 Utah St.		d. STREET ADDRESS (If rural, give location) 4109 Utah St.	

3. NAME OF DECEASED a. (First) EMMA (Type or Print)		b. (Middle) M.	c. (Last) MULCAHY	4. DATE OF DEATH (Month) (Day) (Year) May 2 1950	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct. 28, 1872	9. AGE (In years last birthday) 77	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) East St. Louis, Ill.	
12. CITIZEN OF WHAT COUNTRY?					

13a. FATHER'S NAME John Delmore	13b. MOTHER'S MAIDEN NAME Wilhelmina Swallanstacker	14. NAME OF HUSBAND OR WIFE Daniel J. Mulcahy
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.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Frank Mulcahy 4109 Utah St.

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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Cerebral apoplexy</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Arteriosclerosis</i>		<i>2 years</i>
	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) <i>334X</i>
21d. TIME OF INJURY <i>3:30 P.M.</i>	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 *5/1*, 19*50*, to *5/2*, 19*50*, that I last saw the deceased alive on *5/1*, 19*50*, and that death occurred at *1 P.M.*, from the causes and on the date stated above.

23a. SIGNATURE <i>B. J. Mc Ginnis MD</i>	(Degree or title)	23b. ADDRESS <i>16 Hampton Village</i>	23c. DATE SIGNED <i>5-2-50</i>
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE May 5, 1950	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.

DATE REC'D BY LOCAL REG. MAY 3 1950	REGISTRAR'S SIGNATURE <i>Sasako</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Kriegshauser 4228 S. Kingshighway 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.

Student _____
Student Embalmer

Signed William B. White

Licensed Embalmer No. 4291

P. O. Address 4228 S. Kingstony

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.