

FILED SEP 5 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **28447**  
Registrar's No. **7261**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>mo</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS, MISSOURI</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St Louis 21st</b>	
c. LENGTH OF STAY (in this place) <b>9 Mos. and 14 days</b>		d. STREET ADDRESS (If rural, give location) <b>3858 Kennelly Ave</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>CITY INFIRMARY HOSPITAL</b>			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH				
a. (First) <b>JOHN</b>	b. (Middle) <b>M</b>	c. (Last) <b>MACKKEY</b>	(Month) <b>8</b>	(Day) <b>24</b>	(Year) <b>1950</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>Aug. 3, 1882</b>	9. AGE (In years last birthday) <b>68</b>	IF UNDER 1 YEAR Months <b>31</b>	IF UNDER 48 HRS. Hours <b>1</b>	IF UNDER 15 MIN. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Breeding</b>		11. BIRTHPLACE (State or foreign country) <b>St Louis</b>		12. CITIZEN OF WHAT COUNTRY?	

13a. FATHER'S NAME <b>James Mackey</b>	13b. MOTHER'S MAIDEN NAME <b>Margaret Brady</b>	14. NAME OF HUSBAND OR WIFE <b>Rose Mackey</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>489-16-4765</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Rose Batavia</b>	ADDRESS <b>3808 Kennelly Av.</b>
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>24 days</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cardiac Decompensated</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <b>Cardio-pulmonic syndrome due to cardiac asthma</b>		
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"/>
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21a. ACCIDENT (Specify) <b>SUICIDE</b>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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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? <b>4342</b>
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22. I hereby certify that I attended the deceased from **Nov. 10, 1949**, to **Aug. 24, 1950**; that I last saw the deceased alive on **Aug. 24, 1950**, and that death occurred at **12:10 P. M.**, from the causes and on the date stated above.

23a. SIGNATURE <b>Palmer Duane Bowditch M.D.</b>	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <b>Aug. 28-1950</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Calvary</b>	24d. LOCATION (City, town, or county) (State) <b>St Louis, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>AUG 26 1950</b>	REGISTRAR'S SIGNATURE <b>J. B. Rosster</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Cullinane Brothers</b>	ADDRESS <b>3320 N. Kingshighway</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

*[Handwritten scribble]*

**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 *me*

working under my personal supervision.

Student Embalmer No. ....

Signed

*[Handwritten signature]*

Signed.....  
Student Embalmer

Licensed Embalmer No.

*4699*

P. O. Address

*[Handwritten address]*

**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.