No. 300
10.48

FILED OCT 23 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 35355

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 8918

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

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4766 Cupples

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis 2069
d. STREET ADDRESS (If rural, give location): 4766 Cupples 0

3. NAME OF DECEASED (Type or Print)
a. (First): Bridget
b. (Middle):
c. (Last): McAvoy

4. DATE OF DEATH (Month) Oct (Day) 9 (Year) 1951

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Sept 1. 1870
9. AGE (In years last birthday): 81 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 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: At Home
11. BIRTHPLACE (State or foreign country): St. Louis, Mo. U
12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME: Dennis Mahoney
13b. MOTHER'S MAIDEN NAME: Bridget Beston
14. NAME OF HUSBAND OR WIFE: U.K.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S SIGNATURE OR NAME: Mary Kelly 4766 Cupples — ADDRESS

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) Arteriosclerotic Heart Disease

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cardiac Decompensation
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

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)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 4200

22. *I hereby certify that I attended the deceased from* 8-, 1951, *to* 10-6-, 1951, *that I last saw the deceased alive on* 10-6-, 1951, *and that death occurred at* 5:30 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE: J. McNamara (Degree or title): M.D. U
23b. ADDRESS: 2415 N. Kingsheghway
23c. DATE SIGNED: 10-9-51

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial U
24b. DATE: 10-11-51
24c. NAME OF CEMETERY OR CREMATORY: Calvary
24d. LOCATION (City, town, or county) (State): St. Louis ~~4386 Lindell~~

DATE REC'D BY LOCAL REG.: OCT 9 1951
REGISTRAR'S SIGNATURE: Jo Earl Smith Vale W89
25. FUNERAL DIRECTOR'S SIGNATURE: Cullen & Kelly — ADDRESS: 4386 Lindell

(Licensed Embalmer's Statement on Reverse Side)

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 James A. Lammers

Licensed Embalmer No. 4142

P. O. Address St Louis

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.