

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **36622**  
Registrar's No. **9779**

FILED NOV 13 1952

318

1003

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 <b>Missouri</b> b. COUNTY <b>ST. LOUIS</b>	
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>Koch Mo. 4880</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis City Hospital #1</b>		d. STREET ADDRESS (If rural, give location) <b>Koch Hospital</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>DANIEL</b> b. (Middle) <b>J.</b> c. (Last) <b>MCCARTHY</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>OCT. 21, 1952</b>		
5. SEX <b>Male 0</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Single 0</b>	8. DATE OF BIRTH <b>January 10, 1886</b>	9. AGE (In years last birthday) <b>66</b>	IF UNDER 1 YEAR Months <b>9</b> Days <b>12</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Koch Hospital</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Covington, Kentucky</b>	

12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	13a. FATHER'S NAME <b>John Mc Carthy</b>	13b. MOTHER'S MAIDEN NAME <b>Margaret Crowley</b>	14. NAME OF HUSBAND OR WIFE
---	---	--	-----------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY (If yes, give war or dates of service) <b>495-18-9757 NA</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Katherine Jackson 2500 S. 18th St.</b>	
---	---	--	--

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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Unknown disease of CNS</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) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>ASHD; pulmonary</b>			

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)
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? <b>355X</b>

22. I hereby certify that I attended the deceased from **10-20-52**, 19\_\_\_\_, to **10-21-52**, 19\_\_\_\_, that I last saw the deceased alive on **10-21-52**, 19\_\_\_\_, and that death occurred at **9:50P m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Robert B. Katoms M.D.</b>	23b. ADDRESS <b>1515 Lafayette Avenue</b>	23c. DATE SIGNED <b>10-22-52</b>
--	--	-------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>10/24/52</b>	24c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Covington, Kentucky</b>
---	------------------------------	--	---

DATE REC'D BY LOCAL REG. <b>OCT 23 1952</b>	REGISTRAR'S SIGNATURE <b>J. Carl Smith</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>John H. Gebken Sons 2630 Gravois Ave.</b>
--	---	--

(Licensed Embalmers' Statement on Reverse Side)

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

No. 300  
10.48

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 .....

*Robert Gebken*

Licensed Embalmer No. 4144

P. O. Address 2630 Gravois Ave.

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.