

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42588

State File No.

11227

FILED DEC 17 1954

318

1003

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. _____

1. PLACE OF DEATH
a. COUNTY _____
2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE _____ b. COUNTY _____
Mo.

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis c. LENGTH OF STAY (in this place) 3-days
c. CITY OR TOWN St. Louis d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION: Mo. Baptist Hospital e. STREET ADDRESS (If rural, give location) 19 4001 Washington Blvd. 2199

3. NAME OF DECEASED a. (First) Michael b. (Middle) J. c. (Last) McCourt 4. DATE OF DEATH (Month) (Day) (Year) Dec. 8, 1954

5. SEX M. 6. COLOR OR RACE W. 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W. 8. DATE OF BIRTH Sept. 1, 1874 9. AGE (In years last birthday) 80 If UNDER 1 YEAR Months 3 Days 7 If UNDER 1 HOUR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired- Ins. Salesman 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (City and State or Foreign Country) Ireland 4 12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME Unk. McCourt 13b. MOTHER'S MAIDEN NAME Rose Unk. 14. NAME OF HUSBAND OR WIFE Lydia McCourt

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. _____ 17. INFORMANT'S SIGNATURE OR NAME Mrs. Margaret McCourt, 3853 Lindell Blvd. ADDRESS _____

18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c) MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Anterior Myocardial Heart Disease & decompensation 14 yrs
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. INTERVAL BETWEEN ONSET AND DEATH 14 yrs

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) _____ 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 Jan 1, 1948, to Dec 8, 1954, that I last saw the deceased alive on Dec 7, 1954, and that death occurred at 7:45 a.m., from the causes and on the date stated above.

23a. SIGNATURE Donald E. Keen (Degree or title) M.D. 23b. ADDRESS 3121 N. Grand St. Louis 7, Mo. 23c. DATE SIGNED 12/8/54

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 24b. DATE Dec. 11, 1954 24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery 24d. LOCATION (City, town, or county) (State) St. Louis, Mo.

DATE REC'D BY LOCAL REG. DEC 9 1954 REGISTRAR'S SIGNATURE J. Charles Smith M.D. FUNERAL DIRECTOR'S SIGNATURE Arthur J. Donnelly ADDRESS 3840 Lindell Blvd.

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.....
Signature of Student Embalmer

Signed *Francis Williamson*.....

Licensed Embalmer No. *356*.....

P. O. Address *3840 Le*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.