

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Pagedale 4291	
d. FULL NAME OF HOSPITAL OR INSTITUTION DePaul Hospt		d. STREET ADDRESS (If rural, give location) 6704 Schofield Ave.	

3. NAME OF DECEASED (Type or Print) Margaret McEwan			4. DATE OF DEATH (Month) (Day) (Year) 4/12/55		
a. (First)	b. (Middle)	c. (Last)			

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH March 15 1870	9. AGE (In years last birthday) 85	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
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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) Ireland		12. CITIZEN OF WHAT COUNTRY? USA	
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13a. FATHER'S NAME Hugh Naughan		13b. MOTHER'S MAIDEN NAME Bridget Walsh		14. NAME OF HUSBAND OR WIFE Peter McEwan Dec	
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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) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME John McEwan		ADDRESS 4435 Arnold Ave.	
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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, asthenia, 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)	Central Hemorrhage			2 days
ANTECEDENT CAUSES	DUE TO (b) Asthma - 8 clear			2 yrs
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	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? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
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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)		
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 331X		
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22. I hereby certify that I attended the deceased from July 12, 1928 to 4-12, 1955, that I last saw the deceased alive on 4-12, 1955; and that death occurred at 2:45 P.M., from the causes and on the date stated above.

23a. SIGNATURE Leo J. Reilly, M.D.		(Degree or title)		23b. ADDRESS 730 Hodiamont		23c. DATE SIGNED 4-14-55	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4/15/55	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis Mo.				
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DATE REC'D BY LOCAL REG. APR 14 1955	REGISTRAR'S SIGNATURE C. Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Jos. W. Clark 1125 Hodiamont Ave.				
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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.....

working under my personal supervision.

Student Embalmer No.....

Signed *V E Morris*

Signed.....  
Student Embalmer

Licensed Embalmer No. *3360*

P. O. Address *St Louis, Mo*

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.