

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

16824

State File No.

4178

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 <b>MISSOURI.</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS</b>		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN <b>ST. LOUIS</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSPITAL</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>PAUL</b> b. (Middle) c. (Last) <b>MCNAMEE</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>MAY 10, 1955</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>July 13 1884</b>
9. AGE (In years last birthday) <b>70</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>WALES</b>
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME <b>PETER MCNAMEE</b>	
13b. MOTHER'S MAIDEN NAME <b>MARY MULLEN</b>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give year or dates of service) <b>7/16/1906</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME <b>Rose Roesch.</b>		ADDRESS <b>Above</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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>NECROTIZING ENTERITIS</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>SUBTOTAL GASTRECTOMY, BRONCHOPNEUMONIA, ANURIA</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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>5711</b>	
22. I hereby certify that I attended the deceased from <b>4-25-55</b> , 19____, to <b>5-10-55</b> , 19____, that I last saw the deceased alive on <b>5-10-55</b> , 19____, and that death occurred at <b>5:00A</b> m., from the causes and on the date stated above.			
23a. SIGNATURE <b>William H. Thumme, M.D.</b> (Degree or title)		23b. ADDRESS <b>1515 Lafayette Avenue</b>	
23c. DATE SIGNED <b>5-10-55</b>		24. LOCATION (City, town, or county) (State) <b>LC MAY (23) MO.</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>X CREMATION</b>		24b. DATE <b>MAY 12 1955</b>	
24c. NAME OF CEMETERY OR CREMATORY <b>MT. OLIVE</b>		24d. LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. <b>MAY 11 1955</b>		REGISTRAR'S SIGNATURE <b>Carl Smith M.D.</b>	
25. FUNERAL DIRECTOR'S SIGNATURE <b>Southern Funeral Home</b>		ADDRESS <b>6312 So Grand</b>	

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

JUN 6 1955

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**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 *David Van Fossen*.....

Licensed Embalmer No. *424*.....

P. O. Address *6322 So Sea*.....

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.