

FILED AUG 2 - 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

318

1003

State File No. 24076
5355

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 Mo.				b. COUNTY		
b. CITY OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 6-days		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
d. FULL NAME OF HOSPITAL OR INSTITUTION Incarnate Word Hospital				STREET ADDRESS (If rural, give location) 3934 Russell Ave.				2179		
3. NAME OF DECEASED (Type or Print) Rose		a. (First)		b. (Middle)		c. (Last) Maguire		4. DATE OF DEATH (Month) (Day) (Year) June 20, 1955		
5. SEX F.		6. COLOR OR RACE W.		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) S.		8. DATE OF BIRTH Jan. 6, 1876		9. AGE (in years last birthday) 79		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper - Capital Coal Co.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.				
13a. FATHER'S NAME Phillip Maguire			13b. MOTHER'S MAIDEN NAME Catherine Hogan			14. NAME OF HUSBAND OR WIFE				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) no		16. SOCIAL SECURITY NO. 489-01-6189		17. INFORMANT'S SIGNATURE OR NAME Mrs. Ann Cain, 3934 Russell Ave.					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, asphyxia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH MEDICAL CERTIFICATION Arterio Sclerotic Heart Disease Myocardial Pathology Chronic Nephritis Chronic Otitis Tympanitis Informant's Seal & Signature ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH years years years 6 Days 1 yr		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION None						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? 4200						
22. I hereby certify that I attended the deceased from 6/15, 1955 to 6/20, 1955, that I last saw the deceased alive on 6/19, 1955, and that death occurred at 1:25 a.m., from the causes and on the date stated above.										
23a. SIGNATURE George J. McKean M.D.				23b. ADDRESS 3903 Olive				23c. DATE SIGNED JUN 21 1955		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE June 22, 1955		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.				
DATE REC'D BY LOCAL REG. JUN 21 1955		REGISTRAR'S SIGNATURE J. Carl Smith			25. FUNERAL DIRECTOR'S SIGNATURE 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 Williams*.....

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.