

FILED NOV 23 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 38561

9979

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

|   |  |   |                                     |   |
|---|--|---|-------------------------------------|---|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE<br><b>Missouri</b> |                                     | b. COUNTY   |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>OR<br>TOWN <b>St. Louis</b> |  | c. LENGTH OF STAY (in this place)   | c. CITY OR TOWN<br><b>St. Louis</b> |   |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>St. Louis State Hospital</b>                          |  | e. STREET ADDRESS (If rural, give location)<br><b>3654 Fillmore St.</b>   |                                     | d. Is Residence within limits of a city or incorporated town?<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |

|  |                                  |  |   |  |  |
|--|----------------------------------|--|---|--|--|
| 3. NAME OF DECEASED<br>(Type or Print)   |                                  |  | 4. DATE OF DEATH<br>(Month) (Day) (Year)                              |  |  |
| a. (First)<br><b>John</b>  | b. (Middle)<br><b>A.</b>         | c. (Last)<br><b>McCaffery</b>  | <b>11</b>   |  | <b>15</b>                                  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widowed</b> | 8. DATE OF BIRTH<br><b>Jan. 7, 1866</b>                               | 9. AGE (In years last birthday)<br><b>89</b> | IF UNDER 1 YEAR<br>Months Days             |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Attendant-State Hospital</b> |                                  | 10b. KIND OF BUSINESS OR INDUSTRY  | 11. BIRTHPLACE (City and State or Foreign Country)<br><b>Scotland</b> |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 13a. FATHER'S NAME<br><b>John McCaffery</b>  |  | 13b. MOTHER'S MAIDEN NAME<br><b>Agnes Kelly</b> |  | 14. NAME OF HUSBAND OR WIFE<br><b>Unknown</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)<br><b>no</b> |  | 16. SOCIAL SECURITY NO.<br><b>unknown</b>       |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS<br><b>Dr. D. J. Nack 3654 Fillmore St.</b> |  |

|  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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<br><b>4 hours</b> |  |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary occlusion</b>   |  | ANTECEDENT CAUSES<br>Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____ |  |  |  |  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <b>Senility</b>  |  |  |  |  |  |  |

|   |  |  |  |   |   |  |
|---|--|--|--|---|---|--|
| 19a. DATE OF OPERATION                          |  | 19b. MAJOR FINDINGS OF OPERATION<br><b>420.1</b>   |  |   | 20. AUTOPSY?<br>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?                      |   |  |

22. I hereby certify that I attended the deceased from **7-1-55**, 19\_\_\_\_, to **Nov. 15, 1955**, that I last saw the deceased alive on **Nov. 15, 1955**, and that death occurred at **12:30 am** from the causes and on the date stated above.

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 23a. SIGNATURE (Degree or title)<br><b>R. Hofstadter M.D.</b> |  | 23b. ADDRESS<br><b>5100 Arsenal Street</b>                              |  | 23c. DATE SIGNED<br><b>11-15-55</b>                             |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>removal</b>   |  | 24b. DATE<br><b>11-17-55</b>  |  | 24c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olive Cemetery</b> |  |
|   |  | 24d. LOCATION (City, town, or county) (State)<br><b>Lemay, Missouri</b> |  |   |  |

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| DATE REC'D BY LOCAL REG.<br><b>NOV 16 1955</b> |  | REGISTRAR'S SIGNATURE<br><b>J. Carl Smith M.D.</b> |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS<br><b>Southern Funeral Home 6322 S. Grand Blvd.</b> |  |
|--|--|--|--|--|--|

(Licensed Embalmer's Statement on Reverse Side)

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.....  
*David Van Fossan*

Licensed Embalmer No. 424

P. O. Address St. Louis

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.