

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED DEC 27 1956

State File No. **43474**  
**10941**

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

**I. 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) \_\_\_\_\_

c. CITY OR TOWN **St. Louis**

d. In Residence within limits of a city or incorporated town? Yes  No

d. FULL NAME OF HOSPITAL OR INSTITUTION **5124 Wabada Ave.**

STREET ADDRESS (If rural, give location) **5124 Wabada Ave.**

**3. NAME OF DECEASED**  
a. (First) **MICHAEL** b. (Middle) **JOSEPH** c. (Last) **MC DERMOTT**

**4. DATE OF DEATH** (Month) (Day) (Year) **Nov. 29 1956**

**5. SEX** **Male** **6. COLOR OR RACE** **White** **7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED** **Married**

**8. DATE OF BIRTH** **Apr. 25 1886** **9. AGE** (In years last birthday) **70** if UNDER 1 YEAR Months \_\_\_\_\_ Days \_\_\_\_\_ if UNDER 2 HRS. Hours \_\_\_\_\_ Mins. \_\_\_\_\_

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired) **Retired**

**10b. KIND OF BUSINESS OR INDUSTRY** **United Drug Co.**

**11. BIRTHPLACE** (City and State or Foreign Country) **Ireland**

**12. CITIZEN OF WHAT COUNTRY?** **U.S.A.**

**13a. FATHER'S NAME** **John J. McDermott** **13b. MOTHER'S MAIDEN NAME** **Ann Scanlon** **14. NAME OF HUSBAND OR WIFE** **Gertrude McDermott**

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) \_\_\_\_\_ (If yes, give war or dates of service) \_\_\_\_\_

**16. SOCIAL SECURITY NO.** **489-01-1568** **17. INFORMANT'S SIGNATURE OR NAME** **Gertrude McDermott** **ADDRESS** **5124 Wabada Ave.**

**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\*** (a) **Cerebral arteriosclerosis**

**ANTECEDENT CAUSES**  
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  
DUE TO (b) **General arteriosclerosis**

DUE TO (c) \_\_\_\_\_

**II. OTHER SIGNIFICANT CONDITIONS**  
Conditions contributing to the death but not related to the disease or condition causing death.  
**334X**

**INTERVAL BETWEEN ONSET AND DEATH**  
**many years**  
**many years**  
**yes**

**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?** \_\_\_\_\_

**22. I hereby certify that I attended the deceased from** **2/19/48**, 19\_\_\_\_, to **11/29/56**, 19\_\_\_\_, that I last saw the deceased alive on **11/15/56**, 19\_\_\_\_, and that death occurred at **2:00 AM** from the causes and on the date stated above.

**23a. SIGNATURE** (Degree or title) **M. J. Apperovien M.D.** **23b. ADDRESS** **4339 N. Alameda St.** **23c. DATE SIGNED** **11/29/56**

**24a. BURIAL, CREMATION, REMOVAL** (Specify) **Burial** **24b. DATE** **12/1/56** **24c. NAME OF CEMETERY OR CREMATORY** **Calvary** **24d. LOCATION** (City, town, or county) (State) **St. Louis Mo.**

**DATE REC'D BY LOCAL REG.** **NOV 30 1956** **REGISTRAR'S SIGNATURE** **Carl Smith M.D.** **25. FUNERAL DIRECTOR'S SIGNATURE** **Sullivan** **ADDRESS** **2849 No. Euclid Ave.**

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.....  
*Albert Mayfield*

Licensed Embalmer No. 307.....

P. O. Address.....

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.