

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

10681

FILED MAR 18 1957

318

1003

STATE FILE NUMBER

1897

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u> <span style="margin-left: 100px;">0</span>		c. CITY OR TOWN <u>St. Louis</u> <span style="margin-left: 100px;">8th Ave.</span>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis City Hospital #1</u>		STREET ADDRESS <u>5622 Enright Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Theresa</u> <span style="margin-left: 100px;"><u>McNamara</u></span>		4. DATE OF DEATH <u>February 22, 1957</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 7th. 1885</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-wife</u>		11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>	
13. FATHER'S NAME <u>Matthew P. Brazill</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Beahan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mrs. Harry P. McCarthy</u>		Address <u>5896 Cabanne Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ovarian Carcinoma</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <u>Generalized ovarian Carcinomatosis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>175x</u>	
20c. TIME OF INJURY Hour _____ Month, Day, Year _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____	
20f. CITY, TOWN, OR LOCATION _____		COUNTY _____ STATE _____	
21. I attended the deceased from <u>2-7-57</u> to <u>2-22-57</u> and last saw <sup>her</sup> <sub>him</sub> alive on <u>2-22-57</u> Death occurred at <u>2:35a</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>M. F. Mistachkin M.D.</u>		22b. ADDRESS <u>1515 Lafayette</u>	
		22c. DATE SIGNED <u>FEB 25 '57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>2-26-1957</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis Missouri</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Arthur J. Donnelly 3840 Lindell Blvd.</u>		25. DATE RECD. BY LOCAL REG. <u>FEB 25 '57</u>	
		26. REGISTRAR'S SIGNATURE <u>Carl Smith MD</u>	

Health, Welfare Public Service

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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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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 *Francis Williamson*

Licensed Embalmer No. *356*

P. O. Address *3840 Lind*

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.