

FILED AUG 26 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29726
STATE FILE NUMBER

318

1003

7300

Registration District No.

Primary Registration District No.

Registrar's No.

300
-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If not in hospital, give location) HOSPITAL OR INSTITUTION St. Ann's Home		Length of stay in lb 11-yrs. 86	
3. NAME OF DECEASED (Type or print) First Middle Last Rose McGrath		4. DATE OF DEATH Month Day Year August 3, 1957	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 24, 1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife-at home		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St. Louis, Missouri
13a. FATHER'S NAME Daniel Ratigan		13b. MOTHER'S MAIDEN NAME Mary Doyle	14. NAME OF HUSBAND OR WIFE John McGrath
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Address Mrs. Ann Nonnenkamp, 4200 Rosewood, Pine Lawn
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage of Brain Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cardiovascular Disease with hypertension DUE TO (c) 443.X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 1 day 10 yrs
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.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		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 Death occurred at 8:10 pm. Jan 10/47 to Aug 3/57 and last saw her alive on Aug 3-1957 m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Dr. Wm J. Tanager, Jr.		22b. ADDRESS 5803 Plymouthe Av.	
22c. DATE SIGNED Aug 5/57		22d. LOCATION (City, town, or county) (State) St. Louis, Missouri	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Aug. 6, 1957	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Missouri
24. FUNERAL DIRECTOR Arthur J. Donnelly		25. DATE RECD. BY LOCAL REG. AUG 5 57	
ADDRESS 3840 Lindell Blvd.		26. REGISTRAR'S SIGNATURE Paul Smith MD	

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

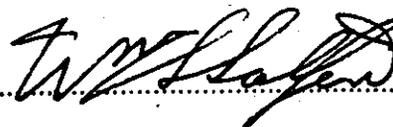
MEDICAL CERTIFICATION

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 me....., Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed



Licensed Embalmer No. 4699
P. O. Address 3840 Terminal

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.