

Health, Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED OCT 4 1957

318

1003

STATE FILE NUMBER 33829
Registrar's No. 8823

Registration District No. Primary Registration District No.

300
-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>ST. LOUIS</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>14 JEWISH HOSP.</u>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <u>2470 4021 WYOMING</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES L. MCGRATH</u>			4. DATE OF DEATH Month Day Year <u>9-18-57</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 25, 1889</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN - LIND REAL ESTATE CO.</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>ST. LOUIS, MO.</u>
13a. FATHER'S NAME <u>FRANK MCGRATH</u>		13b. MOTHER'S MAIDEN NAME <u>NORA WALSH</u>	14. NAME OF HUSBAND OR WIFE <u>Henrietta McGrath</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO NONE</u>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <u>HENRIETTA MCGRATH 4021 WYOMING</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>Myocardial Embolus</u> Condition(s) any, DUE TO (b) <u>Pneumonic Heart Disease</u> which gave rise to (a), DUE TO (c) <u>Auricular fibrillation</u> forming the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>20 hrs.</u> <u>yes</u> <u>yes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>46x</u>			18. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE 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>Aug 1956</u> to <u>Sept 18, 1957</u> and last saw him alive on <u>9-18-57</u> Death occurred at <u>8:30 P.M.</u> of the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Melvin B. Kuster MD.</u>		22b. ADDRESS <u>607 N Grand, St Louis</u>	22c. DATE SIGNED <u>9-20-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>SEP. 21, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>RESURRECTION CEM.</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS CO. MO.</u>
24. FUNERAL DIRECTOR ADDRESS <u>KRIEGSHAUSER 4228 S. KINGSHIGHWAY</u>		25. DATE RECD. BY LOCAL REG. <u>SEP 20 '57</u>	26. REGISTRAR'S SIGNATURE <u>J. Carl Smith MD</u> <u>SMG</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Richard W. Storer*

Licensed Embalmer No. *4007*

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.