

pt. Health,
c. & Welfare
S. Public
alth Service

FILED NOV 27 1957

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

318

1003

11083

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

S. 300
v. 1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis. Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Johns Hospital		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 205 1/2 STREET ADDRESS 956 Hamilton, Ave. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Anna Middle Last McCarthy			4. DATE OF DEATH Month Nov. Day 18, Year 1957		
--	--	--	---	--	--

5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 13, 1870	9. AGE (In years last birthday) 87	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
-------------------------	----------------------------------	---	--	--	--------------------------------	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Saleslady	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Illinois.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
---	-----------------------------------	--	---

13a. FATHER'S NAME Michael McCarthy	13b. MOTHER'S MAIDEN NAME Mary Dwyer	14. NAME OF HUSBAND OR WIFE Nil.
---	--	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No. Nil.	16. SOCIAL SECURITY NO. None	17. INFORMANT Reavy Funeral Home, Jacksonville, Illinois. Address
--	--	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO (b) Generalized Arteriosclerosis DUE TO (c) Aplastic anemia 5 years		INTERVAL BETWEEN ONSET AND DEATH Terminal Unknown
---	--	---

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.)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
---	--	---

20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <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 1952 to Nov 18, 1957 and last saw her alive on Nov 12, 1957 Death occurred at 4:20 AM on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Degree or title) Nemroy J. MD	22b. ADDRESS 634 W. Grand	22c. DATE SIGNED 11/19/57
---	-------------------------------------	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 11-18-57	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) Jacksonville, Illinois.
---	------------------------------	---	---

24. FUNERAL DIRECTOR Albert H. Hoppe	ADDRESS 4700 Washington, Blvd.	25. DATE RECD. BY LOCAL REG. NOV 19 57	26. REGISTRAR'S SIGNATURE Earl Smith MD
--	--	--	---

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

2183

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 *John J. Hannes*
 Licensed Embalmer No. 4108
 P. O. Address St. Louis, Mo.

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.