THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-003248
STATE FILE NUMBER
2 631

FILED FEB 3 1959 Registration District No. ..... Primary Registration District No. ..... Registrar's No. .....

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St.Louis — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): St.John's Hosp. — Length of stay in 1b: 2-wks.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY
c. CITY OR TOWN: St.Louis — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 5915 Waterman Ave. — Reside on Far Yes [ ] No [ ]

7057

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Lillian — Last: McWay
4. DATE OF DEATH: Month Jan. Day 17 Year 1959
5. SEX: F.
6. COLOR OR RACE: W.
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Oct.30,1893
9. AGE (In years last birthday): 65
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): Housewife-at Home
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Owensbobo,Ky.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: William Blandford
14. MOTHER'S MAIDEN NAME: Martha Hayden
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Dr.Thomas J.McWay, Address: 5915 Waterman Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Generalized Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: unknown
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Carcinoma of Recto-Sigmoid — unknown
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Uremia, Hydro Nephrosis, Diabetes Mellitus
19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]
20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 154X
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 1/5/59, to 1/17/59 and last saw (her/him) alive on 1/17/59
Death occurred at 12:15 pm on the date stated above; and to the best of my knowledge, from the causes stated
22a. SIGNATURE: Joseph V. O'Donnell (Degree or title) MD
22b. ADDRESS: 539 N Grand
22c. DATE SIGNED: 1/19/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Jan.20,1959
23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery
23d. LOCATION (City, town, or county) (State): St.Louis,Mo.
24. FUNERAL DIRECTOR: Arthur J. Donnelly — ADDRESS: 3840 Lindell Blvd.
25. DATE RECD. BY LOCAL REG.: JAN 19 '59
26. REGISTRAR'S SIGNATURE: Karl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was by me, or by ....., Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 4

P. O. Address 3840 Je

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. 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.