

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 2 wks	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DePaul Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5885 Plymouth

3. NAME OF DECEASED (Type or print) First James Middle J. Last McGroarty			4. DATE OF DEATH Month Nov. Day 1 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-31-85	9. AGE (last birthday) 75

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY Electric	11. BIRTHPLACE (City and state or country) Maryville, Mo.	12. CITIZEN OF WHAT COUNTRY U. S.
13a. FATHER'S NAME James McGroarty	13b. MOTHER'S MAIDEN NAME Annie Cassidy	14. NAME OF HUSBAND OR WIFE Georgeanna Walker McGroarty	

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. 493-03-6878	17. INFORMANT Address Mrs. Georgeanna McGroarty, 5885 Plymouth
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, bilateral		INTERVAL BETWEEN ONSET AND DEATH Weeks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Carcinoma of esophagus, 14 months growth	
	DUE TO (c) 150 X	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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.)
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	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 10 Oct 1960 to 1 Nov, 1960 and last saw her/him alive on 1 Nov. 1960 Death occurred at 7:15 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE (Degree or title) James C. Vest M.D.	22b. ADDRESS 634 N. Howard	22c. DATE SIGNED 11/4/60
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11-5-60	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery
24. FUNERAL DIRECTOR ADDRESS White-Mullen Mortuary, Ferguson, Mo.		23d. LOCATION (City, town, or county) (State) St. Louis, Mo.

25. DATE RECD. BY LOCAL REG. NOV 4 1960	26. REGISTRAR'S SIGNATURE Neal Smith M.D.
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DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

James
1905

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
or by self _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Reinhold K. Lohr

Licensed Embalmer No. 338

P. O. Address St Louis

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