

REC'D OCT 12 1938

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

31076  
Do not use this space.

## 1. PLACE OF DEATH

(a) County.....  
(b) Township.....  
(c) City St. Louis, Mo  
(e) Length of residence in city or town where death occurred yrs. mos. ds.

Registration District No. 791  
Primary Registration District No. 1003

Registered No. 8513

(d) Street No. BARNES HOSPITAL St.  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(f) How long in U. S., if of foreign birth? yrs. mos. ds.

## 2. PRINT FULL NAME

Mabel H. McCawley (M. Cawley) 241  
(a) Residence, No. Winston Churchill Apts. St. 3  
5475 Cabanne (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF O. J. McCawley  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 27 1880  
7. AGE YEARS 57 MONTHS 10 DAYS 0 If LESS than 1 day, hrs. or min.  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. at home  
9. Industry or business in which work was done, as saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year)  
11. Total time (years) spent in this occupation

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-27-38  
22. I HEREBY CERTIFY, That I attended deceased from 9-23, 1938, to 9-27, 1938.  
I last saw her alive on 9-27, 1938. Death is said to have occurred on the date stated above, at 2:40 p.m.  
The principal cause of death and related causes of importance were as follows:  
Remission of Cervix Uteri  
Pneumonia Terminal

Date of onset

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Missouri

Other contributory causes of importance:

13. NAME Morris B. Hilliard  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Boston Mass.

Name of operation..... Date of.....  
What test confirmed diagnosis? Biopsy..... Was there an autopsy? Yes

15. MAIDEN NAME Melvina Hardtippe  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Boston Mass.

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide?..... Date of injury....., 19.....  
Where did injury occur?.....  
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

17. INFORMANT (ADDRESS) Jane H. McCawley  
# 5475 Cabanne

Manner of injury.....  
Nature of injury.....

18. BURIAL, CREMATION, OR REMOVAL PLACE Bellefontaine DATE 9-29-38

24. Was disease or injury in any way related to occupation of deceased?.....  
If so, specify.....  
(Signed) J. F. Nolan, M. D.

19. FUNERAL DIRECTOR (NAME) (ADDRESS) C. R. Wmpton & Sons  
7233 Delmar Blvd.20. FILE NO. SEP 28 1938 J. Predeck Local Registrar.(Address) BARNES HOSPITAL

**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,

*Bradford A. Miles*

, or by

Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed

*Bradford A. Miles*

Licensed Embalmer No.

*2901*

P.O. Address \_\_\_\_\_

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING: (Failure to conform with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**