

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPT AUG 17 1939 791

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH: **1008**  
 (a) County \_\_\_\_\_  
 (b) City or town **St. Louis**  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: **LITTLE SISTERS**  
**2209 Hebert Street.**  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **6 Months**  
 In this community **Dont Know.**  
 years, months or days

3. (a) PRINT FULL NAME **Patrick Pendergrast. 5316**  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single.**  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased **March 2 1868**  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**71 4 1** hr. min.

9. Birthplace **Ireland**  
 (City, town, or county) (State or foreign country)

10. Usual occupation **Laborer**

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name **Henry Pendergrat**  
 13. Birthplace **Ireland.**  
 (City, town, or county) (State or foreign country)  
 14. Maiden name **Catherine McCarthy**  
 15. Birthplace **Ireland.**  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Sister Pendergrast**  
 (b) Address **2209 Hebert St**

17. (a) **Burial** (b) Date thereof **July 4, 1939**  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation **Calvary**

18. (a) Signature of funeral director **Arthur J. Donnelly**  
 (b) Address **3840 Lindell Blvd**

19. (a) **JUL 4 1939** (b) \_\_\_\_\_  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State **Mo.** (b) County \_\_\_\_\_  
 (c) City or town **St. Louis.** **20**  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. **2209 Hebert Street.**  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month **July** day **3**  
 year **1939** hour **11:00** minute **9** A. M.  
 21. I hereby certify that I attended the deceased from **June 12**  
 \_\_\_\_\_, 19**39** to **July 3,** 19**39**  
 that I last saw him alive on **July 3,** 19**39**  
 and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
**Chronic Myocarditis**  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions **Arteriosclerosis**  
 (Include pregnancy within 3 months of death)  
 Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following: **No**  
 (a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_  
 (c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
 \_\_\_\_\_ (Specify type of place)  
 While at work? \_\_\_\_\_ (Specify type of place)  
 23. Signature **Anthony A. Pekaroski, M.D.**  
 Address **1525 a Curo Ave** Date signed **7/3/39**

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**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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

*Alfred J. Boedeltje*

Licensed Embalmer No.....

*2663*

P. O. Address.....

*4284 Prairie*

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

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

23634

Do not use this space.

1. PLACE OF DEATH *St Louis*  
(a) County *St Louis* Registration District No. *791*  
(b) Township *St Louis* Primary Registration District No. *1003* Registered No. *5907*  
(c) City *St Louis* (d) Street No. \_\_\_\_\_ (If death occurred in Hospital or Institution, write its name instead of street and number) St.  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.  
2. PRINT FULL NAME *Patricia Pendergrast*  
(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *S*

21. DATE OF DEATH (MONTH, DAY, AND YEAR) \_\_\_\_\_, 19\_\_\_\_

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
*71 4 1*

The principal cause of death and related causes of importance were as follows:

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_  
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 \_\_\_\_\_

Date of onset \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN), (STATE OR COUNTRY) *Pendergrast Ireland*

Other contributory causes of importance: \_\_\_\_\_

FATHER 13. NAME *Henry Pendergrast*

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

14. BIRTHPLACE (CITY OR TOWN), (STATE OR COUNTRY) *Ireland*

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

MOTHER 15. MAIDEN NAME \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:

16. BIRTHPLACE (CITY OR TOWN), (STATE OR COUNTRY) \_\_\_\_\_

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

17. INFORMANT (ADDRESS) \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

18. BURIAL, CREMATION, OR REMOVAL

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

PLACE \_\_\_\_\_ DATE \_\_\_\_\_, 19\_\_\_\_

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

19. FUNERAL DIRECTOR (ADDRESS) \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

20. FILED *9-25-39* 19\_\_\_\_ *J. B. Budek* Local Registrar.

If so, specify \_\_\_\_\_

(Signed) \_\_\_\_\_, M. D.

(Address) \_\_\_\_\_

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.  
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SUPPLEMENTARY

