

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

Registration District No. 252 Primary Registration District No. 3036 Registrar's No. 137

1. PLACE OF DEATH:
(a) County ST CHARLES
(b) City or town ST. CHARLES
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Carmelite Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12 yrs (Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County 1
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME MARY JANE KAUAUGH
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 9th day 9th
year 1939 hour 2 minute 30 A. M.

4. Sex Female 5. Color or race WHITE 6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife MICHAEL 6. (c) Age of husband or wife if alive Actual years
7. Birth date of deceased MAR 22 1857
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from June, 1936, to Sept 9th, 1939
that I last saw her alive on Sept 8th, 1939, and that death occurred on the date and hour stated above.

8. AGE: Years 82 Months 5 Days 17 If less than one day _____ hr. _____ min.

Immediate cause of death Senility Duration 3 yrs
Due to _____
Due to _____

9. Birthplace ST LOUIS MO
(City, town, or county) (State or foreign country)

Other conditions Ortho's Deformity 12 yrs
(Include pregnancy within 3 months of death)

10. Usual occupation Nick
11. Industry or business None
MOTHER FATHER { 12. Name J. LYNCH
18. Birthplace IRELAND
14. Maiden name Dora Kora
15. Birthplace DO NOT KNOW

Major findings: Of operations none
Of autopsy none
PHYSICIAN _____
Underline the cause to which death should be charged statistically

16. (a) Informant's own signature Walter Miller
(b) Address M. Loran NW
17. (a) Burial (b) Date thereof Sept 12 1939
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cem
18. (a) Signature of funeral director A. J. Donnelly
(b) Address 3840 Lindbergh Blvd. St. Louis Mo
19. (a) 9/9/39 (b) Clarence S. Thesler
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
(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?
While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature B. L. Newkirk (M. D. or other) MD
Address St. Charles Mo Date signed 9/9/39

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. Boedeker

Licensed Embalmer No. _____

2663

P. O. Address _____

4204 Praine

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.