

NOV 13 1939
791
1003

Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County Mo Baptist Hosp
(b) City or town St Louis Mo
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME Carrie McCullough
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife George 6. (c) Age of husband or wife if alive 72 years
7. Birth date of deceased Mar 15 1868 (Month) (Day) (Year)

8. AGE: Years 71 Months 6 Days 25 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name David Parks

13. Birthplace Ohio (City, town, or county) (State or foreign country)

14. Maiden name Mary Jane Parks

15. Birthplace Ohio (City, town, or county) (State or foreign country)

16. (a) Informant's own signature George McCullough

(b) Address 2832 Burdway

17. (a) Burial (b) Date thereof 10/12/39 (Month) (Day) (Year)

(c) Place: burial or cremation Friedens Cemetery

18. (a) Signature of funeral director Sullivan

(b) Address 2849 No E 41th

19. (a) OCT 10 1939 (Date received local registrar) (b) J. J. [Signature] (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Cal St Louis
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. 2832 Burd (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct, day 9, year 1939 hour 11 minute 22 P.M.

21. I hereby certify that I attended the deceased from Oct 4, 1939, to Oct 9, 1939; that I last saw her alive on Oct 9, 1939; and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombosis
Due to Chronic myocarditis 5 days

Due to _____
Other conditions Mild hypertension 3 years

Major findings: Of operations _____
Of autopsy _____

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 Virgil O. Fish (M. D. or other) _____
Address 635 W. [Signature] St. Date signed 10-10-39

Duration
5 days
years?
PHYSICIAN
Underline the cause to which death should be charged statistically.

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.

Dr Virgil O Fish
Mo Theatre Bldg
FR 5588

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

Henry C. Limes

Registered Apprentice No. *170*

working under my personal supervision.

Signed

Al Mayfield

Licensed Embalmer No.

3077

P. O. Address

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.