

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 8740

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. 2223

1. PLACE OF DEATH:
(a) County _____
(b) City or town ST LOUIS
(c) Name of hospital or institution:
5247 GREER AVE 2
(d) Length of stay: In hospital or institution _____
In this community 70 YEARS
years, months or days

3. (a) PRINT FULL NAME CATHERINE VAUGHAN
(b) If veteran, name war. N.O.
(c) Social Security No. NONE

4. Sex FEMALE race WHITE
5. Color or race WHITE
6. (a) Single, widowed, married, divorced WIDOWED
6. (b) Name of husband or wife JOHN
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased APRIL 6 1862
(Month) (Day) (Year)

8. AGE: Years 77 Months 10 Days 26
If less than one day hr. 5 min.

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

10. Usual occupation HOUSE WORK

11. Industry or business HOME

12. Name PETER CLARK
13. Birthplace UNKNOWN IRELAND
(City, town, or county) (State or foreign country)
14. Maiden name MAX KIRK
15. Birthplace UNKNOWN IRELAND
(City, town, or county) (State or foreign country)

16. (a) Informant John Vaughan
(b) Address 5247 GREER

17. (a) BURIAL (b) Date thereof 3-6-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation CALVARY

18. (a) Signature of funeral director Cullen Kelly
(b) Address 1416 N. TAYLOR AVE

19. (a) MAR 5 1940
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County _____
(c) City or town ST. LOUIS 6
(d) Street No. 5247 GREER
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 3rd
year 1940 hour 9:00 minute 55 P.M.

21. I hereby certify that I attended the deceased from Sept. 1st 1939 to March 3rd 1940
that I last saw her alive on Feb. 28 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Dilatation of the heart muscle
Duration _____

Due to Hypertension for some months
arterio-sclerosis

Due to _____
Other conditions Diabetes Mellitus
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(Specify type of place) _____
While at work? _____ (e) Means of injury _____

23. Signature Dr. J. P. Murphy
Address 2116 N. Kingsley Hwy. Date signed 3/4/40
(M. D. or other) none

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

MOTHER FATHER

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

Clement McNeary

Licensed Embalmer No. 3732

P. O. Address St. Louis

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.