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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 15 1941 7917

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 40321
10092

Registration District No. _____ Primary Registration District No. 1003 Registrar's No. _____

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township) 2

(c) Name of hospital or institution: 3004 North Newstead Ave
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

(c) City or town St. Louis 10
(If outside city or town limits, write "RURAL")

(d) Street No. 3004 North Newstead Ave
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Margaret Cather

3. (b) If veteran, name war _____

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Roy Cather

6. (c) Age of husband or wife if alive 47 ~~60~~ years

7. Birth date of deceased Nov (Month) 12th (Day) 1888 (Year)

8. AGE: Years 58 Months 0 Days 26 If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) Ireland 5 (State or foreign country)

10. Usual occupation Housewife 5

11. Industry or business _____ 5

MOTHER FATHER

12. Name Timothy Reagan 5

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

14. Maiden name Ellen Sullivan

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

16. (a) Informant Roy Cather

(b) Address 3004 North Newstead Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/11/40 (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Stroot - Carroll

(b) Address 4600 Natural Bridge Ave

19. (a) DEC 9 1940 (Date received local registrar) (b) J. H. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 8th year 1940 hour 7 minute 06a M.

21. I hereby certify that I attended the deceased from December 39 _____, 19 _____ to Dec. 8 _____, 19 40 that I last saw her alive on Dec 6 _____, 19 40 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral hemorrhage	7 days
Due to Arterio-sclerosis (with hypertension 240/150)	5 years
Due to _____	
Other conditions (Include pregnancy within 3 months of death) Myocardial degeneration	

Major findings:
Of operations N/A
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:

(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? _____ (e) Means of injury _____

23. Signature I. Ste. Turnbake (M. D. or other) M.D.

Address 4622 N. Taylor Date signed 12/9/40

(Licensed Embalmer's Statement on Reverse Side)

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 [signature]

Licensed Embalmer No. 2265

P. O. Address 46 [illegible] N A Bridge a

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

If this body is not embalmed, fact should be so stated above.