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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 727  
Registrar's No. 727

**FEB 25 1941**  
Registration District No. \_\_\_\_\_

Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(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 of Poor  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1-Year  
(Specify whether years, months or days)

In this community 5-Years

3. (a) PRINT FULL NAME John William McFadden

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex M. 5. Color or race W.

6. (a) Single, widowed, married, divorced D.S.

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Feb. 1st., 1868  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>72</u>	<u>11</u>	<u>22</u>	hr. _____ min.

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

10. Usual occupation Retired

11. Industry or business Tailor

MOTHER FATHER {

12. Name James McFadden

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

14. Maiden name Eileen Monnahan

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

16. (a) Informant Mr. Joseph McFadden

(b) Address Route #2, Festus, Mo.

17. (a) Burial (b) Date thereof 1-24-1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Hope

18. (a) Signature of funeral director Arthur J. Donnelly

(b) Address 3840 Lindell Blvd.

19. (a) JAN 23 1941 (b) [Signature]  
(Data received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County DOO

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

(d) Street No. 3225 N. Florissant Ave.  
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 23rd.  
year 1941 hour 5 minutes 30 a. M.

21. I hereby certify that I attended the deceased from Dec. 24, 1940 to Jan. 23, 1941  
that I last saw him alive on Jan. 22  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis  
Duration 1 Month

Due to \_\_\_\_\_

Due to Arteriosclerosis

Other conditions None  
(Include pregnancy within 3 months of death)

Major findings: None

Of operations \_\_\_\_\_

Of autopsy None

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? \_\_\_\_\_

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

23. Signature Anthony G. [Signature] (M. D. or other) MD

Address 1525 Al Cuso Ave Date signed 1/23/41

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 *W Van Matre*

Licensed Embalmer No. *2825*

P. O. Address *4340 Lafayette*

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, fact should be so stated above.