

2
4-41
7-39
X2839

Registration District No. **791**

Primary Registration District No. **1002**

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:
Enroute City Hospital # 13
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **36 years**
years, months or days)

3. (a) PRINT FULL NAME

Timothy McCarthy

3. (b) If veteran, name war **no** 3. (c) Social Security No. _____

4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **single**

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Mar. 3, 1891**
(Month) (Day) (Year)

8. AGE: Years **50** Months **9** Days **10** If less than one day _____ hr. _____ min.

9. Birthplace **Co. county Cork Ireland**
(City, town, or county) (State or foreign country)

10. Usual occupation **Common laborer**

11. Industry or business _____

12. Name **Daniel Mc Carthy**

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

14. Maiden name **Julia Mahoney**

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

16. (a) Informant **Margaret Reed**

(b) Address **4747 Beacon Ave**

17. (a) **burial** (b) Date thereof **12-30-41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **Goodrich & Goodrich**

(b) Address **2228 St. Louis Ave**

19. (a) **DEC 29 1941** (b) **J. F. Medeck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **4747 Beacon Ave**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **27th**
year **1941** hour **9:30** minute **A.** M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Acute Stenosis

Due to **Chronic Myocarditis**

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

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? _____

While at work? _____ (Specify type of place to which means of injury)

23. Signature **[Signature]** (M. D. or other) _____

Date signed **12/29/41**

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

MOTHER FATHER

Photo

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 *Charles Goodhart*
Licensed Embalmer No. *2777*
P. O. Address *St Louis Mo*

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.