

FILED JUN 29 1947 91

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County.....
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3940 Labadie 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
(If outside city or town limits, write "RURAL")
(d) Street No. 3940 Labadie Ave.
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 14
year 1947 hour 5 minute 20 A. M.

21. I hereby certify that I attended the deceased from
March 14 1946, to June 14 1947
that I last saw her alive on June 13 1947
and that death occurred on the date and hour stated above.

Immediate cause of death
Myocardial Infarction
Due to arteriosclerosis
Due to hypertension
Other conditions
(Include pregnancy within 3 months of death)
92

Duration

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) (Means of injury)
23. Signature W. N. [unclear] (M. D. or other)
Address 703 N. King St. [unclear] Date signed 6-14-47

3. (a) PRINT FULL NAME MARY C. CAHILL
3. (b) If veteran, name war..... 3. (c) Social Security No.

4. Sex Female 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 November 15th, 1852
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
89 6 29 hr. min.

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

10. Usual occupation Housework

11. Industry or business.....

12. Name James Cahill

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

14. Maiden name Margaret (unknown)

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

16. (a) Informant Minnie E. Parson

(b) Address 3940 Labadie Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-16-42
(Month) (Day) (Year)

(c) Place: burial or cremation Int. Bellefontaine Cem.

18. (a) Signature of funeral director: Sullivan Brothers

(b) Address 2849 No. Euclid Ave.

19. (a) JUN 15 1947 (Date received local registrar) J. F. [unclear] (Registrar's signature)

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.....

Albert Mayfield

Licensed Embalmer No.....

2077

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.