9-4-41
5-17-39
X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

185

State File No.

FILED JAN 19 1943

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 290

1. PLACE OF DEATH:

(a) County St Louis Mo.

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

(c) Name of hospital or institution: ~~1518~~ 520 Hickory St (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 000 12 22

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

(d) Street No. 520 Hickory St. (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME JOSEPHINE M.G. DERMOTT

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 1

6. (b) Name of husband or wife

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

7. Birth date of deceased Aug (Month) - 10 (Day) - 1867 (Year)

8. AGE: Years 75 Months 5 Days 2 If less than one day hr. min.

9. Birthplace Kentucky (City, town, or county) 1 (State or foreign country)

10. Usual occupation House wife

11. Industry or business

FATHER
12. Name Mr Coonner.
13. Birthplace Ireland (City, town, or county) 4 (State or foreign country)

MOTHER
14. Maiden name Mrs Martin
15. Birthplace Ireland (City, town, or county) 4 (State or foreign country)

16. (a) Informant Thomas McDermott

(b) Address 1518 Montgomery

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 14 1943 (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director J. J. Dennis

(b) Address 1389 Union Blvd.

19. (a) JAN 12 1943 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 11 year 1943 hour 3 minute 00 P.M.

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

Immediate cause of death Chronic Myocarditis Chronic Interstitial Nephritis

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Alfred G. Perry (M. D. or other)

Address Dupont Avon Date signed 1/13/43

(Licensed Embalmer's Statement on Reverse Side)

Embalmers separable certificate to be filled

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.....

Licensed Embalmer No.....

P. O. Address.....

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.

V. S. No. 2B
0M—8-21-41
1 X29288

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STANDARD CERTIFICATE OF DEATH

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Registration District No. 318 | Primary Registration District No. | Registrar's No. 290

1. PLACE OF DEATH:

(a) County

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

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

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

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

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

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Josephine M. B. Clermott

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F | 5. Color or race W | 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Thomas

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

7. Birth date of deceased Aug (Month) 10 (Day) 1868 (Year)

8. AGE: Years 75 | Months 5 | Days 28 | If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

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

14. Maiden name

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) FEB 20 1943 (Date received by local registrar) (b) J. F. Burbeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Day
year 1943 hour minute 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

Due to

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.

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(c) Where did injury occur? (City or town) (County) (State)

(b) 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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

LTSL = 0f