

No. 2
-2-43
5-17-39
I X35897

State File No.

FILED FEB 11 1944

Registration District No. Primary Registration District No. **1003** Registrar's No. **1090**

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:
725 CLARENDON 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 **Mo** (b) County.....
(c) City or town **ST LOUIS**
(If outside city or town limits, write "RURAL")
(d) Street No. **725 CLARENDON AVE**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **MARY AGNES PASCAULT**
3. (b) If veteran, name war..... 3. (c) Social Security No.....

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **FEB** day **1st**
year **1944** hour **8** minute **30 P.** M.

4. Sex **FEMALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **WIDOW**
6. (b) Name of husband or wife **HENRY G PASCAULT** 6. (c) Age of husband or wife if alive **7** years
7. Birth date of deceased: **JUNE 7 1872**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Feb 19 34**, 19... to **Feb 1 44**, 19...
that I last saw her alive on **Feb 1, 1944**, 19...
and that death occurred on the date and hour stated above.

8. AGE: Years **71** Months **7** Days **24** If less than one day
hr. min.

Immediate cause of death **Serumemia**

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

Due to **Bacteria Sclerosis - aneurysm & dilatation of heart**
Due to **Op & Serumemia**

10. Usual occupation **AT HOME**

Other conditions (Include pregnancy within 3 months of death) **74**

11. Industry or business

MOTHER FATHER { 12. Name **THOMAS MEAGHER**
13. Birthplace **IRELAND** (City, town, or county) (State or foreign country)
14. Maiden name **ELIZABETH WALSH**
15. Birthplace **IRELAND** (City, town, or county) (State or foreign country)

Major findings: Of operations
Of autopsy
PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant **Mrs Josephine McCullough**
(b) Address **725 Clarendon Ave.**

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?

17. (a) **BURIAL** (Burial, cremation, or removal) (b) Date thereof **FEB 4 - 1944**
(Month) (Day) (Year)
(c) Place: burial or cremation **CALVARY CEM.**

18. (a) Signature of funeral director **J. Mullen Ind Co.**
(b) Address **5165 Delmar, Wash.**

19. (a) **FEB 3 1944** (Date filed for registration) (b) **J. D. Bredeich** (Registrar's signature)

While at work? (Specify type of place) (c) Means of injury:
23. Signature **Raepe Rellies** (M. D. or other)
Address **Mo Bldg. Insurance** Date signed **2/7/44**

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

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 H. G. Harris
Licensed Embalmer No. 3384
P. O. Address St Louis

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.