

S. No. 2
M-2-43
15-17-39
-1 X35637

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39318

FILED DEC 23 1944

State File No.

Registration District No.

Primary Registration District No. 1003

Registrar's No. 10692

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:
St. Louis City Hospital - Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days
In this community 1 years, months or days (Specify whether)

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. 1250 So. Vandeventer
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

1817

3. (a) PRINT FULL NAME Catherine Fagan

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 Married
6. (b) Name of husband or wife Nov. Philip 6. (c) Age of husband or wife if alive 73 years
7. Birth date of deceased Nov 25 1878
(Month) (Day) (Year)

8. AGE: Years 65 Months 0 Days 18 If less than one day hr. _____ min. _____

9. Birthplace St. Louis Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Housework

11. Industry or business at Home

MOTHER FATHER { 12. Name John Gray
13. Birthplace Ireland 4
(City, town, or county) (State or foreign country)
14. Maiden name Ellen Obrien
15. Birthplace Ireland 4
(City, town, or county) (State or foreign country)

16. (a) Informant Philip Fagan
(b) Address 1250 So. Vandeventer Ave

17. (a) Burial (b) Date thereof 12 16 44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director KRIEGSHAUSER

(b) Address 4228 So. Kingshighway

19. (a) DEC 15 1944 (b) Medical
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 13th
year 1944 hour 10:35 minute P. M. 44
21. I hereby certify that I attended the deceased from 12/11/44
Dec. 13th 19 44
that I last saw her alive on Dec. 13th 19 44
and that death occurred on the date and hour stated above.

Immediate cause of death Robert C. Anderson
Duration _____

Due to _____
Due to _____ 108

Other conditions (Including pregnancy within 3 months of death) Generalized arteriosclerosis
Major findings: _____
Of operations _____

Of autopsy Same
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 James J. Scott 1515 Lafayette 12/15/44
Address Date signed

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 Edwin D. McDermott

Licensed Embalmer No. 3024

P. O. Address.....

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.