

V. S. No. 2
FORM-5-43
Rev. 5-17-39
I X38671

FILED NOV 3 1945

Primary Registration District No. **1003**

Registrar's No. **9363**

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

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution: St. John's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 26 days
(Specify whether)

In this community 60 yrs.
years, months or days

3. (a) PRINT FULL NAME Minnie McCarthy

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 W.

6. (b) Name of husband or wife John R. McCarthy

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

7. Birth date of deceased Jan. 6th., 1870
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>75</u>	<u>9</u>	<u>22</u>	hr. _____ min. _____

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

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER

12. Name: Unknown McCann

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

14. Maiden name: Unknown Mahoney

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

16. (a) Informant Mrs. Margaret Vogler

(b) Address 5024 Christy Blvd.

17. (a) Burial
(Burial, cremation, or removal)

(b) Date thereof 10-31-45
(Month) (Day) (Year)

(c) Place: burial or cremation burial

18. (a) Signature of funeral director Arthur J. Donnelly

(b) Address 3840 Lindell Blvd.

19. (a) OCT 29 1945
(Date received local registrar)

J. F. Bradeck
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 000

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

(d) Street No. 4343 Forest Park Blvd.
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No) 0

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 28th., year 1945 hour 9 minute 05 a.m.

21. I hereby certify that I attended the deceased from 10-2-45, 19, to 10-9-45, 19, that I last saw her alive on 10-9-45, 19, and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerosis with Cerebral thrombosis

Due to _____

Due to _____

Other conditions Fracture of femur
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy none

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) Kill in home

(b) Date of occurrence 10-2-45

(c) Where did injury occur? At her residence Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? In home
(Specify type of place)

While at work? no

(c) Means of injury Kill getting out of bed.

23. Signature John J. Hammond (M. D. or other) 10/29/45

Address 634 W. Grand Date signed _____

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 W H Van Matre

Licensed Embalmer No. 2825

P. O. Address. 4340 Lafayette

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.