

S. No. 2  
M-5-43  
7. 5-17-39  
P I X36671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **38948**  
Registrar's No. **11002**

**FILED** DEC 28 1945  
Registration District No. **318**

Primary Registration District No. **1003**

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:  
**1109 So. Kingshighway Blvd.**  
(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)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Mo.** (b) County **St. Louis**  
(c) City or town **St. Louis**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **1109 So. Kingshighway Blvd.**  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME **James P. Brady**  
3. (b) If veteran, name war..... 3. (c) Social Security No.....  
4. Sex **M.** 5. Color or race **W.** 6. (a) Single, widowed, married, divorced **M.**  
6. (b) Name of husband or wife **Lillie Brady** 6. (c) Age of husband or wife if alive **54** years  
7. Birth date of deceased **Sept. 6th., 1889**  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH, Month **Dec.** day **15th.**, year **1945** hour **12** minute **15** p. M.  
21. I hereby certify that I attended the deceased from **10-15**, 19**45** to **12-15**, 19**45**;  
that I last saw h. alive on **12-14**, 19**45**, and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
**56** **3** **9** hr. min.

Immediate cause of death **Carcinoma of Tongue**  
Duration

9. Birthplace **St. Louis** **Mo.**  
(City, town, or county) (State or foreign country)  
10. Usual occupation **Dispatcher**  
11. Industry or business **Public Service Co.**

Other conditions **Anemia**  
(Include pregnancy within 3 months of death)  
Major findings: Of operations **H5**  
Of autopsy.....  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

MOTHER FATHER  
12. Name **Michael Brady**  
13. Birthplace **Ireland**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Emma Forrest**  
15. Birthplace **St. Louis** **Mo.**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Lillie Brady**  
(b) Address **1109 So. Kingshighway Blvd.**  
17. (a) **Burial** (b) Date thereof **12-18-45**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Calvary**

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?

18. (a) Signature of funeral director **Arthur J. Donnelly**  
(b) Address **3840 Lindell Blvd.**  
19. (a) **DEC 17 1945** **J. F. Bredeck**  
(Date received by registrar) (Registrar's signature)

While at work?..... (Specify type of place) (c) Means of injury **0**  
23. Signature **H. L. Bremer** (M. D. or other)  
Address **4266 Manchester** Date signed **12-17-45**

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**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 Stanley Marshall  
Licensed Embalmer No. 2868  
P. O. Address 3840 Kindeell

**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.**