

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

FILED MAY 31 1946

Primary Registration District No. **1003**

Registrar's No. **3594**

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

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: CITY HOSPITAL  
(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 Boon

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

(d) Street No. 6267 FAMOUS AVE  
(If rural, give location)

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME COBLE, CATHERINE

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APR day 18 year 1946 hour 4 minute 23 P.M.

4. Sex FEMALE 5. Color or race WHITE

6. (a) Single, widowed, married, divorced WIDOW

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased 8-30-1866  
(Month) (Day) (Year)

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.

8. AGE:	Years	Months	Days	If less than one day
	<u>79</u>	<u>7</u>	<u>18</u>	hr. _____ min. _____

Immediate cause of death Basin fracture of skull  
When she fell backward down the  
steps at her home on April 17  
1946 about 11:45 A.M.

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

Due to 1866

Other conditions (include pregnancy within 3 months of death)

10. Usual occupation HOUSE WIFE

11. Industry or business \_\_\_\_\_

12. Name LIMITAY HARRINGTON

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

14. Maiden name CATHERINE DONOVUE

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

Major findings: Of operations 18

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant WILLIAM J. HARRINGTON

(b) Address 6267 FAMOUS AVE

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

(b) Date thereof 4/20/46  
(Month) (Day) (Year)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accidental

(b) Date of occurrence April 17 1946

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

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home

(c) Place: burial or cremation CADIZ

18. (a) Signature of funeral director M. J. Conaghan

(b) Address 7146 Maple Street

While at work \_\_\_\_\_ (Specify type of place)

Means of injury as above

23. Signature Alfred J. Brudeck (M. D. or other)

Address 1021 1/2 E. 11th St. Date signed 4/19/46

19. (a) APR 19 1946 (Date received local registrar)

J. F. Brudeck (Registrar's signature)

13495

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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: *John Agnoski*  
Licensed Embalmer No. *3398*

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.**