

S. No. 2
M-543
7-5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **32518**
Registrar's No. **8960**

FILED OCT 4 1947
Registration District No. **1947 318**

Primary Registration District No. **1003**

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:
Missouri Baptist Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 day
 (Specify whether
 In this community.....
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County oac
 (c) City or town St. Louis 17
 (If outside city or town limits, write "RURAL")
 (d) Street No. 5330 Gilson 9
15 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No) 0
 If yes, name country.....

3. (a) PRINT FULL NAME Margaret L. Gaffney
 (b) If veteran, name war *****
 (c) Social Security No. 489-07-8738

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September, day 24th
 year 1947 hour 4 minute 05 A. M.

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced Single
 (b) Name of husband or wife..... 6. (c) Age of husband or wife if
 alive..... years
 7. Birth date of deceased November 1st, 1901
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from May 23, 1947, to Sept 24, 1947
 and that death occurred on the date and hour stated above.
 that I last saw her alive on Sept 24, 1947.

8. AGE:

| Years | Months | Days | If less than one day |
|-----------|-----------|-----------|----------------------|
| <u>45</u> | <u>10</u> | <u>23</u> |hr.min. |

Immediate cause of death.....
Cerebral Hemorrhage 2 1/2 hrs
 Due to.....
 Due to.....

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

Other conditions.....
 (Include pregnancy within 3 months of death)
Arterio Sclerosis 27
 Major findings:
 Of operations.....
 Of autopsy.....

10. Usual occupation Housemaid
 11. Industry or business #2 Oak Knoll

MOTHER FATHER

12. Name William M. Gaffney
 13. Birthplace Memphis Tenn.
 (City, town, or county) (State or foreign country)
 14. Maiden name Margaret Canavan
 15. Birthplace St. Louis Missouri
 (City, town, or county) (State or foreign country)

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)
 (i) Means of injury.....

16. (a) Informant Mrs. Joseph C. Cissell
 (b) Address 5330 Gilson, St. Louis, Mo.
 17. (a) burial (b) Date thereof 9/27/47
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Resurrection Cemetery

23. Signature George P. Allen (M. D. or other) 720
 Address 812 Olive Street Date signed 9/26/47

18. (a) Signature of funeral director Wacker-Block U.S. Co.
 (b) Address SEP 25 1947 Gravois, St. Louis, Mo.
 19. (a) (Date received local registrar) (b) J.P. Brebeck
 (Registrar's signature)

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.....

Frank J. O'Keefe

Licensed Embalmer No.....

2045

P. O. Address.....

St. Louis, Mo

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.