

0. 300
10-47
17-39
I 3906

#87351
FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED JUL 15 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

20786
State File No. _____
Registrar's No. 5960

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis, Mo.
(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
(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 Mo. (b) County 000
(c) City or town St. Louis, Mo. Ave. 17
(If outside city or town limits, write "RURAL")
(d) Street No. 5078 Cabanne Ave. 9
Memorial (If rural, give location) 0
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME PATRICK DARRAUGH
3. (b) If veteran, name war No
3. (c) Social Security No. 489-03-7014

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 3rd
year 1948 hour 8 minute 45 A M.
21. I hereby certify that I attended the deceased from 7/2/48
_____, 19____, to July 3rd, 1948;
that I last saw h im alive on July 3rd, 1948;
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Divorced
6. (b) Name of husband or wife Mary Darraugh 6. (c) Age of husband or wife if alive ? years
7. Birth date of deceased Feb. 7, 1897
(Month) (Day) (Year)

Immediate cause of death
Cerebral hemorrhage, right middle cerebral artery 72 hr
Due to Arteriosclerosis,
Due to 9/4/48
Other conditions Myocardial infarction old
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day
51 4 26 hr. min.

9. Birthplace Weir, Kansas (City, town, or county) (State or foreign country)
10. Usual occupation Retired Cutter
11. Industry or business _____

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy Same.
Underline the cause to which death should be charged statistically.

MOTHER FATHER
12. Name James Darraugh
13. Birthplace Ireland (City, town, or county) (State or foreign country) 4
14. Maiden name Grace Duff
15. Birthplace Ireland (City, town, or county) (State or foreign country) 4

16. (a) Informant Mrs. Grace Bruce
(b) Address Tyler, Texas
17. (a) Burial (b) Date thereof July 6/48
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery
18. (a) Signature of funeral director Jos. W. Clark
(b) Address 1125 Hodiamont Ave.
19. (a) JUL 5 1948 (b) J. F. Briceak
(Date received local registrar) (Registrar's signature)

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) Means of injury _____
23. Signature 518 Lafayette 7/3/48 or other _____
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

Alfred J. Boeleker

Licensed Embalmer No. 2663

P. O. Address 1125 Hodiamont Ave.,

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.