

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **7750**
Registrar's No. **1790**

FILED MAR 11 1953

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. LENGTH OF STAY (in this place) 10 mos		2019	
d. FULL NAME OF HOSPITAL OR INSTITUTION 915 KOELN		d. STREET ADDRESS (If rural, give location) 915 Koeln	
3. NAME OF DECEASED a. (First) Maude (Type or Print)		b. (Middle) McCarthy c. (Last)	
4. DATE OF DEATH Feb. 12, 1953		5. SEX female	
6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	
8. DATE OF BIRTH Jan. 29 - 1879		9. AGE (In years last birthday) 74	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (City and State or Foreign Country) Bonne Terre, Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Billie Bryant		13b. MOTHER'S MAIDEN NAME unknown	
14. NAME OF HUSBAND OR WIFE John McCarthy		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME John McCarthy, 915 Koeln	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Senility DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR 4500		22. I hereby certify that I attended the deceased from July 6, 1952 to Feb 12, 1953 , that I last saw the deceased alive on Feb 10, 1953 , and that death occurred at 12:30 m. ; from the causes and on the date stated above.	
23a. SIGNATURE Ray C. Dripps M.D.		23b. ADDRESS 7712 Brown Ave	
23c. DATE SIGNED 2/13/53		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
24b. DATE 2/16/53		24c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cem	
24d. LOCATION (City, town, or county) (State) Lemay 23, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Fendler Und. Co., 7420 Michigan	
DATE REC'D BY LOCAL REG. FEB 16 1953		REGISTRAR'S SIGNATURE J. Earl Smith M.D.	

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

Dripps

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Ronald B. Yahrke

Licensed Embalmer No.

3917

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.