

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-009286

STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 447

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAR 5 1962

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY _____	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Richmond Heights		c. CITY OR TOWN St. Louis	
Length of stay in 1b DAYS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Hospital		d. STREET ADDRESS (If outside, give location) 4402 McPherson Ave.	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First MADELINE Middle G Last McCARTHY			4. DATE OF DEATH Month Feb. Day 3rd Year 1962		
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5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9-16-1899	9. AGE (last birthday) 62	IF UNDER 1 YEAR Months 19 Days 19 Hours _____ Min. _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (City and state or country) New York City, N.Y.	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME John Gilligan	13b. MOTHER'S MAIDEN NAME Bridget Kilcullen	14. NAME OF HUSBAND OR WIFE Ray F. McCarthy
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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 Ray McCarthy Address 4402 McPherson
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Coma 581.0		INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) Cerebrus of liver		
DUE TO (c) Tracheo bronchitis		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____		

PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year _____
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20d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office Bldg., etc.) _____	20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____
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21. I attended the deceased from **1955** to **2-3-62** and last saw her alive on **2-3-62**.
Death occurred at **St. Mary's Hospital** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) [Signature]	22b. ADDRESS 4161 Lunder Blvd	22c. DATE SIGNED 2/5/62
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23a. BURIAL, CREMATION, or other disposal REMOVAL	23b. DATE Feb. 6, 1962	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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24. FUNERAL DIRECTOR ADDRESS A. H. BOCKLAGE 6536 Clayton Rd.	25. DATE RECD. BY LOCAL REG. 2-5-62	26. REGISTRAR'S SIGNATURE [Signature]
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 ITEM NO. _____ SHOULD READ _____
 BY AFFIDAVIT OF _____
 MEDICAL CERTIFICATION _____
 DOCUMENT _____
 INSTEAD OF _____
 DATE AMENDED _____
 VS 300 Rev. 4/59
 14805
 2 219
 3
 4 1
 5 1
 6
 7 1
 8 1
 9
 10
 11
 12 46-0
 13
 46
 USE BLACK INK OR TYPEWRITER RIBBON

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 _____
Signature of Student Embalmer

Signed Harvey Kahle

Licensed Embalmer No. 4596

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

Wm. S. Crumley