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DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

MISSOURI STATE BOARD OF HEALTH STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 784

Primary Registration District No. 111

Registrar's No. 1722

1. PLACE OF DEATH:
 (a) County St. Louis
 (b) City or town Richmond Heights
 (If outside city or town limits, write "RURAL" and name of township)
at home
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution none
years (Specify whether years, months or days)
 In this community _____

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County St. Louis
 (c) City or town Richmond Heights
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1021 Yale Ave.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME MARY HEARN 650
3. (b) If veteran, name war. None **3. (c) Social Security No.** None
4. Sex F. **5. Color or race** W. **6. (a) Single, widowed, married, divorced** Single
6. (b) Name of husband or wife. None **6. (c) Age of husband or wife if alive.** None years
7. Birth date of deceased. MAY 18th 1868
 (Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept. day 30 year 1939 hour 11:45 minute A. M.
21. I hereby certify that I attended the deceased from June 1937 to Sept 30 1939
June 30, 1937 to Sept 30, 1939
 that I last saw her alive on Sept 30, 1939
 and that death occurred on the date and hour stated above.

8. AGE: Years 71 Months 4 Days 12 If less than one day hr. _____ min. _____
9. Birthplace. St. Louis Missouri
 (City, town, or county) (State or foreign country)

Immediate cause of death Cerebral Apoplexy Duration 2 days
 Due to Hypertension
 Due to _____

10. Usual occupation Housewife
11. Industry or business None
MOTHER FATHER
12. Name John Ahearn
13. Birthplace Tipperary Ireland
 (City, town, or county) (State or foreign country)
14. Maiden name Jane Maginn
15. Birthplace County Louth Ireland
 (City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) _____
 Major findings: gza! **PHYSICIAN** _____
 Of operations _____
 Of autopsy _____
 Underline the cause to which death should be charged statistically

16. (a) Informant's own signature Mellie E. Suen
(b) Address 1021 Yale Ave.
17. (a) Burial Calvary **(b) Date thereof** October 3 1939
 (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Calvary
18. (a) Signature of funeral director Hatzen Backlage
(b) Address 653 1/2 Clayton Road
19. (a) OCT 2 1939 **(b) G. A. Meyer**
 (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) _____
Signature Tho. J. Harlow (M. D. or other) _____
Address 940 Bell Ave **Date signed** 10/1/39

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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..... *Tom Rogers*

Licensed Embalmer No. *3905*

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, above space should be left blank.