

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

542
542

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Barnes
(b) City or town St. Louis, Missouri
(c) Name of hospital or institution: City Hospital, #1
(d) Length of stay: In hospital or institution 7 Days
abt. 35 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis, 26
(d) Street No. 1518 Hogan
(e) If foreign born, how long in U. S. A. Abt. 35 years.

3. (a) PRINT FULL NAME Pat Brennan 655

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Abt. 1877
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
Abt. 62 hr. min.

9. Birthplace Ireland
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer 5
Odd Jobs 7

11. Industry or business _____

12. Name Unknown 9

13. Birthplace unknown
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature J. M. White
(b) Address 1128 N. 4th Street

17. (a) Burial (b) Date thereof Jan. 18, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Bernard Nicholas
(b) Address 1431 Union Bl'vd

19. (a) Jan 18 1940 (b) J. D. [Signature]
(Date received local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 16,
year 1940 hour 9:50 minute _____ A. M.

21. I hereby certify that I attended the deceased from January
10, 1940 to January 16, 1940

that I last saw him alive on January 16, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Septicemic? Heart Disease

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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) (e) Means of injury _____

23. Signature J. D. [Signature] (M. D. or other) _____
Address 1515 Lafayette, 1/16/40
Date signed

WRITE PLAIN!—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

No Embalming

Licensed Embalmer No.....

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.