

Registration District No. Primary Registration District No.

1. PLACE OF DEATH:
(a) County 2
(b) City or town ST. LOUIS
(c) Name of hospital or institution: 2232 A.S. JEFFERSON AV.
(d) Length of stay: In hospital or institution _____
In this community _____
years, months or days

3. (a) PRINT FULL NAME KATE O'Loughlin
(b) If veteran, name war _____
(c) Social Security No. _____

4. Sex FEMALE
5. Color or race WHITE
6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife Andrew
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased NOV. 4 1860
(Month) (Day) (Year)

8. AGE: Years 79 Months 3 Days 22
If less than one day _____ hr. _____ min.

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

10. Usual occupation HOUSEWORK

11. Industry or business _____
12. Name ANDREW BREEN
13. Birthplace IRELAND
14. Maiden name MARY UNK
15. Birthplace IRELAND

16. (a) Informant Mama Wichmann
(b) Address 2232 S. Jefferson av

17. (a) BURIAL (b) Date thereof MARCH 1-1940
(c) Place: burial or cremation NEW ST. MARCUS

18. (a) Signature of funeral director E. J. Schmur
(b) Address 3125 Lafayette av

19. (a) FEB 24 1940 (b) _____
(Date received local Registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County _____
(c) City or town ST. LOUIS 23
(d) Street No. 2232 A.S. JEFFERSON AV.
(e) If foreign born, how long in U. S. A. ? _____ years

MEDICAL CERTIFICATION
20. DATE OF DEATH, Month Feb day 26
year 1940 hour 6 minute 50 M.

21. I hereby certify that I attended the deceased from Jan 10 1940 to Feb 26 1940
that I last saw her alive on Feb 25 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis
Due to 93c
Due to _____

Other conditions arteriosclerosis
(includes pregnancy within 6 months of death) Cholera stasis
Major findings: Bones
Of operations _____

Of autopsy Yes
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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____ (Specify type of plane) _____
Means of injury 1
23. Signature Otto C. Hansen (M. D. or other) _____
Address 3157 1/2 Park av Date signed 2/24/40

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 Jose B. Wallmer

Licensed Embalmer No. 21014

P. O. Address 3125 Lafayette 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, above space should be left blank.