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1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 8 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

12418

State File No. _____

Registration District No. 784

Primary Registration District No. 111

Registrar's No. 548

I. 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)
(c) Name of hospital or institution:
St. Mary's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 23 Days
(Specify whether
In this community 53 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4247 Cleveland Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 53 Years years.

8. (a) PRINT FULL NAME Sarah M. Cregan

8. (b) If veteran, name war None 8. (c) Social Security No. None

4. Sex F. 5. Color or race W. 6. (a) Single, widowed, married, divorced W.

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

7. Birth date of deceased May 15th., 1863
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
76 10 1 hr. _____ min.

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

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER { 12. Name James Hennessey

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

14. Maiden name Margaret Hickey

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

16. (a) Informant Elizabeth H. Cregan

(b) Address 4247 Cleveland Ave

17. (a) Burial (b) Date thereof 3-19-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Arthur J. Donnelly

(b) Address 3840 Lindell Blvd

19. (a) MAR 18 1940 (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. 16th.,
year 1940 hour 9 minute 0 P. M.

21. I hereby certify that I attended the deceased from Feb 23
1940 to March 6, 1940
that I last saw her alive on 3/16/40, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Acute myocardial infarction
Duration _____
Direct cause Chronic bronchitis & emphysema
Due to fractured hip
un-unioned

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

Major findings: Of operations _____

Of autopsy no

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no

(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?
no

While at work? _____ (Specify type of place)

23. Signature James J. Madigan M. D. or other _____

Address 200 W. 11th St. St. Louis Date signed 3/16/40

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

144B
9A

OK
15-3
X

5

Jan. 20 1933

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 Stanley Marshall

Licensed Embalmer No. 2868

P. O. Address 3840 Lindell Blvd

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.

**MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 12418
Registrar's No. 548-

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County St. Louis Mo.
(b) City or town Rich. Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
.....
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
(Specify whether
In this community.....
years, months or days)

3. (a) PRINT FULL NAME Sarah M. Cregan -

3. (b) If veteran, name war..... 3. (c) Social Security No.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W

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

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

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

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a)..... (b)..... (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town..... (If outside city or town limits write "RURAL")
(d) Street No..... (If rural, give location)
(e) If foreign born, how long in U. S. A.?..... years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Mar 16 1932 -
year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....; that last saw him..... alive on....., 19....., and that death occurred on the date and hour stated above.

Immediate cause of death Acute heart failure
Chr. Myocarditis.
Chr. bronchitis

Due to.....

Due to fracture hip rt - un united

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

Major findings:
Of operations.....

Of autopsy.....

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 4/8/32

(c) Where did injury occur? Home (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? tripped and fell over a carpet

While at work?..... (Specify type of place) Means of injury.....

23. Signature James P. Wade (M. D. or other).....

Address..... Date signed.....

SUPPLEMENTARY

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

MOTHER FATHER

1940
5-12418