

WRITE PLAINLY—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.

JUN 15 1940 791  
Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:  
(a) County St. Louis,  
(b) City or town St. Louis,  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
3523a N. Neustead. 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 29 years  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri. (b) County \_\_\_\_\_  
(c) City or town St. Louis 10  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3523a N. Neustead  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Thomas Egan 750  
(b) If veteran, name war none  
(c) Social Security No. NONE

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Widow  
6. (b) Name of husband or wife Julia Egan  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased May 5, 1892  
(Month) (Day) (Year)

8. AGE: Years 47 Months 11 Days 25  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation City of St. Louis  
Water Department

11. Industry or business \_\_\_\_\_  
12. Name Thomas Egan  
18. Birthplace Ireland  
14. Maiden name Katherine Pormi  
15. Birthplace Ireland  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Margaret Egan  
(b) Address 3523a N. Neustead  
17. (a) Burial (b) Date thereof May 16, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Calvary Cemetery  
18. (a) Signature of funeral director Bensick-Mehar  
(b) Address 1451 Union Blvd.  
19. (a) MAY 2 1940 (b) \_\_\_\_\_  
(Date of local registrar) (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 30  
year 1940 hour 4 minute 30 M.  
21. I hereby certify that I attended the deceased from Apr 12-1940  
to Apr 29-1940  
that I last saw ~~him~~ her alive on Apr 29  
and that death occurred on the date and hour stated above.

Immediate cause of death Hemorrhage Duration \_\_\_\_\_  
Due to Cirrhosis of liver  
Due to \_\_\_\_\_  
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 \_\_\_\_\_  
(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. F. Brecken M.D. (M. D. or other) \_\_\_\_\_  
Address 2901 N. Neustead Date signed 4/30/40

Number 151/201

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**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.....

*R. M. White*

Licensed Embalmer No.....

*3973*

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.**