

Registration District No. _____ Primary Registration District No. _____

FILED OCT 7 1940
OCT 21 1940

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
5104A Page Blvd.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community Life
years, months or days (Specify whether)

3. (a) PRINT FULL NAME Sarah Callahan

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Thomas F 6. (c) Age of husband or wife if alive Deed years

7. Birth date of deceased June 15th 1865
(Month) (Day) (Year)

8. AGE: Years 75 Months 2 Days 23 If less than one day hr. _____ min. _____

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

10. Usual occupation At Home

11. Industry or business _____

12. Name Dennis Green

13. Birthplace Ireland
(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 Dorothy Callahan

(b) Address 5104 A Page Blvd

17. (a) Burial (b) Date thereof 9/10/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cent

18. (a) Signature of Harrison & Sheahan Ind Co

(b) SEP 9 1940 4415 Washington Blvd

19. (a) _____ (b) J. P. Prudeck
(Date received local registrar) (Registrar's signature)

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. 5104A Page Blvd
(If rural, give location)
(e) If foreign born, how long in U. S. A.? Life years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 8th.
year 1940 hour 3:00AM minute _____ M.

21. I hereby certify that I attended the deceased from Jan 1, 1940, to Sept 8, 1940
that I last saw her alive on 9-7-40, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to chronic hypertension

Due to _____
Other conditions (include pregnancy within 3 months of death) gza

Major findings: Of operations _____

Of autopsy _____

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 E. H. Bowdren (M. D. or other) _____
Address 6347 Grand Date signed 9-8-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

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 _____

J. G. Sullivan

Licensed Embalmer No. 1122

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.