

FILED SEP 21 1943 18

Registration District No. _____

Primary Registration District No. **1003**

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: **ST. JOHN'S HOSPITAL**
(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 **FRANCIS P. ROONEY**

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

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 _____

7. Birth date of deceased **MARCH 12 1867**
(Month) (Day) (Year)

8. AGE: Years **76** Months **5** Days **23** If less than one day _____ hr. _____ min.

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

10. Usual occupation **NIL**

11. Industry or business _____

MOTHER FATHER { 12. Name **MICHAEL ROONEY**
13. Birthplace **NEW YORK**
(City, town, or county) (State or foreign country)
14. Maiden name **MARY O'DAY**
15. Birthplace **NEW YORK**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mr. Joseph Rooney**

(b) Address **562 Andrews**

17. (a) **BURIAL** (b) Date thereof **SEPT 14 43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **OLD S.S.P. + P. CEM.**

18. (a) Signature of funeral director **E. J. Schmur.**

(b) Address **3125 Lafayette Ave.**

19. (a) **SEP 16 1943** (b) **J. J. Bredeck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **St. Louis**
(c) City or town **ST. LOUIS KIRKWOOD**
(If outside city or town limits, write "RURAL")
(d) Street No. **562 ANDREWS, NR.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **SEPT** day **14**
year **1943** hour **12:55** minute **A.M.**

21. I hereby certify that I attended the deceased from **1-28-43**
_____, 19____, to **9-11-43**, 19____;

that I last saw him alive on **9-11-43**, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Auto-Coroner Failure** Duration **7 days**

Due to **Myocardial Regeneration - Passive Pulmonary edema** years _____

Due to **Chc. Nephritis - Chc. Hemiplegia** " _____
Chc. Gall Bladder Double " _____

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

Major findings: Of operations **none**

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? _____

23. Signature **George S. McKean MD** (Specify type of place) _____
Address **3903 Olive Street** (City or town) (State) _____
Date signed **9/14/43**

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

100
117
9

8235

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.....

Harry J. Schumacher

Licensed Embalmer No..... *2679*

P. O. Address..... *732 Lemay Ferry rd*

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, fact should be so stated above.