S. No. 2
DM—2-43
v. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 14 1945 348

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

1003

State File No. 25593

Registration District No. ____ Primary Registration District No. ____ Registrar's No. 7533

**1. PLACE OF DEATH:**

(a) County ____

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: De Paul 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)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County ____

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 5046a Wabada Avenue,
(If rural, give location)

(e) Citizen of foreign country? ____ (Yes or No)
If yes, name country ____

3. (a) PRINT FULL NAME THOMAS B. EAGAN

3. (b) If veteran, name war ____

3. (c) Social Security 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 alive ____ years

7. Birth date of deceased September (Month) 24th (Day) 1881 (Year)

8. AGE: Years 63 Months 11 Days 4 If less than one day ____ hr. ____ min.

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

10. Usual occupation ____

11. Industry or business Dry Goods Store

FATHER
12. Name John Eagan
13. Birthplace St. Louis, Mo (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mary (unknown)
15. Birthplace St. Louis, Mo (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Nellie Barrett-Sister
(b) Address 5046a Wabada Avenue,

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 8-30-1945 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Sullivan Brothers,
(b) Address 2849 North Euclid Avenue,

19. (a) AUG 29 1945 (Date received local registrar) (b) J. F. Bedeck (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Aug day 28 year 1945 hour 1 minute 30 A.M.

21. I hereby certify that I attended the deceased from July 16, 1945 to Aug 28, 1945 that I last saw him alive on Aug 27, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Heart failure with Myocardial failure — Duration 1 day

Due to Carcinoma of Hepatic — Duration 6 months

Due to Pelvic of Colon — Duration 4 yr

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations Carcinoma of Hepatic Pelvic & Sigmoid resection

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? ____ (Specify type of place)

While at work? ____ (e) Means of injury ____

23. Signature ____ (M. D. or other)

Address 4768 Delmar Date signed 8/28/45

(Licensed Embalmer's Statement on Reverse Side)

Jo.4350

Dr. Kohler
at 12:30 P.M. Tues.
office (4968 a Delmar)

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 Robert Brinkman

Licensed Embalmer No. 3553

P. O. Address St Louis Mo

**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.**