

S. No. 2
M-5-43
v. 5-17-39
p. 1 X36671

DEPARTMENT OF COMMERCE THE STATE BOARD OF HEALTH OF MISSOURI
BUREAU OF THE CENSUS
FILED FEB 20 1946 STANDARD CERTIFICATE OF DEATH

State File No. **7460**
Registrar's No. **1425**

Registration District No. **318** Primary Registration District No. **1002**

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

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:
5325 Quincy
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 000
(c) City or town St. Louis (If outside city or town limits, write "RURAL") 2/17
(d) Street No. 5325 Quincy (If rural, give location) 9
(e) Citizen of foreign country? _____ (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME Thomas F. Geoghegan
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb. day 10
year 1946 hour 3 minute 30 A.M.

4. Sex male 5. Color or race white
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Catherine 6. (c) Age of husband or wife if alive 57 years
7. Birth date of deceased Dec. 18 1885
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan. 29 1946 to Feb 10 1946
that I last saw him alive on Feb 10 1946
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
60 1 22 hr. _____ min.

Immediate cause of death Cerebral Hemorrhage Duration _____

9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)
10. Usual occupation Deputy Sheriff

Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

11. Industry or business _____
12. Name Michael Geoghegan
13. Birthplace Ireland (City, town, or county) (State or foreign country) 4
14. Maiden name Mary Rush
15. Birthplace Ireland (City, town, or county) (State or foreign country) 4

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant Norvell Geoghegan
(b) Address 5325 Quincy
17. (a) Burial (b) Date thereof 2-13-46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Calvary
18. (a) Signature of funeral director J.L. Ziegenhein & Sons
(b) Address 7027 Gravois Ave.
19. (a) FEB 12 1946 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

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 B. E. Maeller (M. D. or other) 0
Address 2537 S. Jefferson Date signed 2/14/46

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 *Sheldon Collier*

Licensed Embalmer No. *3382*

P. O. Address *7029 Gravin*

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.