

FILED OCT 28 1946

State File No. _____

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **8859**

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. Louis City 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 **Mo.** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **3225 No. Florissant Ave.**
(If rural, give location) _____
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **John J. Ahern**
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex **M.** 5. Color or race **W.**
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 **Unknown 1876**
(Month) (Day) (Year)

8. AGE: **70** Years Months Days If less than one day
Unknown hr. min.

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

10. Usual occupation **Teamster**

11. Industry or business _____

MOTHER FATHER { 12. Name **Eugene Ahern**
13. Birthplace **Ireland**
(City, town, or county) (State or foreign country)
14. Maiden name **Mary O'Brien**
15. Birthplace **Ireland**
(City, town, or county) (State or foreign country)

16. (a) Informant **Thomas J. Finan**
(b) Address **4869 Carter Ave.**

17. (a) **Burial** (b) Date thereof **10-18-46**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **Arthur J. Donnelly**
(b) Address **3840 Russell Blvd. St. Louis, Mo.**

19. (a) **OCT 16 1946** (b) **J. F. Bisset**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Oct.** day **15th.**
year **1946** hour _____ 6. minute **05** A. M.
21. I hereby certify that I attended the deceased from _____
_____ 19____ to _____ 19____
that I last saw him _____ alive on _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death **Supraventricular hemorrhage of brain, lobar pneumonia, fracture of left elbow - when deceased was found lying on the concrete porch of the rear of the house at the back of the porch on Oct 13 1946 about 5:25 P.M.**
Died _____
(Included pregnancy within 3 months of death)
Cause of death **Unknown**
Manner of death **Could not be ascertained**

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

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) **Open Verdict**
(b) Date of occurrence **Oct 13 1946**

(c) Where did injury occur? **at home**
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Rear of Home

(Specify type of place) _____
While at work? _____ (e) Means of injury **fall**

23. Signature of physician **Patricia E. Taylor**
(M.D. or other) _____
Address **1300 Clark** Date signed **10 15 46**

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

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 Stanley Marshall

Licensed Embalmer No. 2868

P. O. Address 3840 Lundell

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.