No. 2
-1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 32522

FILED SEP 23 1947

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 8725

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

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution: City Infy. Hospital O
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9-14-44/915-47 (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town City St Louis. 17
(If outside city or town limits, write "RURAL")

(d) Street No. 5800 Arsenal St. 9
(If rural, give location) 0

(e) Citizen of foreign country? 13 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Edward Gannon.

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male O

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife FLORA

6. (c) Age of husband or wife if alive years

7. Birth date of deceased 9 (Month) 7 (Day) 1876 (Year)

8. AGE: Years 71 Months Days 8 If less than one day hr. min.

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

10. Usual occupation Shoe Worker

11. Industry or business

FATHER
12. Name Mack Gannon O
13. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

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

16. (a) Informant City Infirmary Records
(b) Address 5800 Arsemal

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/17/47 (Month) (Day) (Year)

(c) Place: burial or cremation Mt Olive Cemetery

18. (a) Signature of funeral director Mark Treinon
(b) Address 6100 W. Florissant Ave

19. (a) SEP 19 1947 (Date received local registrar) (b) J. F. Biedeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 15
year 1947 hour 11 minute 15; a.m.

21. I hereby certify that I attended the deceased from 9 14 1944 to 9 14 1947
that I last saw her alive on 9-15- 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac failure
Aortic aneurism, luetic
Due to aortitis, aortic insufficiency
Due to Pulmonary emphysema
Other conditions
(Include pregnancy within 3 months of death)
Cardiac hypertrophy
Major findings:
Of operations
Of autopsy

Duration

PHYSICIAN

Underline the cause of 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 O

23. Signature Warren C. Lewis (M. D. ~~or other~~)

Address 5600 Arsenal Date signed 9-11-47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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 Mark Tiernan

Licensed Embalmer No. 4174

P. O. Address 6100 W. Florissa

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.