

FILED MAR 4 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5995

State File No.

Registration District No. **318** Primary Registration District No.Registrar's No. **1771**

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: **City Hospital**
 (If not in hospital or institution, write street number or location)
24 hrs.
 (d) Length of stay: In hospital or institution..... (Specify whether
 In this community.....
 years, months or days)

3. (a) PRINT FULL NAME **John Joseph Anglin**3. (b) If veteran, name war **World War I** 3. (c) Social Security No.4. Sex **Male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **widower**6. (b) Name of husband or wife **Jennie Anglin** 6. (c) Age of husband or wife if alive **abt 1893** years

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

8. AGE: Years **abt - 54** Months Days If less than one day hr. min.9. Birthplace..... (City, town, or county) (State or foreign country) **Washington**10. Usual occupation **retired**

11. Industry or business

12. Name **John Anglin**
 13. Birthplace **Ireland**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Margaret Holloran**
 15. Birthplace **Ireland**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Marie Hoagland**
(b) Address **1604 Cass Ave.**17. (a) **burial** (b) Date thereof **2-23-1948**
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation **Calvary Cemetery**18. (a) Signature of funeral director **Harrigan & Shearan**(b) Address **4415 Washington Bl.**19. (a) **FEB 20 1948** (Date received local registrar) **J. F. Bredeck** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

1008 Missouri
 (a) State **Missouri** (b) County **St. Louis**
 (c) City or town **St. Louis**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **1804 Cass Ave.**
 (If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **19** year **1948** hour **12** minute **40P**

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 **Arterial Aneurysm** Duration

Due to.....

Due to.....

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

Major findings: Of operations.....

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?.....

While at work?..... (Specify type of place) (c) Means of injury **3**23. Signature **Patrick & Taylor** (M. D. or other).....Address **Deputy Coroner** Date signed **2-20-48**

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

MAY 7 1948

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.....

J. Allen Davis
.....
Licensed Embalmer No. *4053*
.....
P. O. Address: *St. Louis*
.....

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. March
Registrar's No. 1771

Registration District No. 314 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:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether
In this community..... (Specify whether
years, months or days)

3. (a) PRINT FULL NAME John J. Anglin
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 and
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased. att (Month) (Day) (Year)

8. AGE: att 54 Years Months Days (If less than one day, hr. min.)

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name.....

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant..... (b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director..... (b) Address.....

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

2. USUAL RESIDENCE OF DECEASED:
(a) State..... (b) County.....
(c) City or town..... (If outside city or town limits, write "RURAL")
(d) Street No..... (If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb year 1948 hour..... minute..... M.
21. I hereby certify that I attended the deceased from..... 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.....

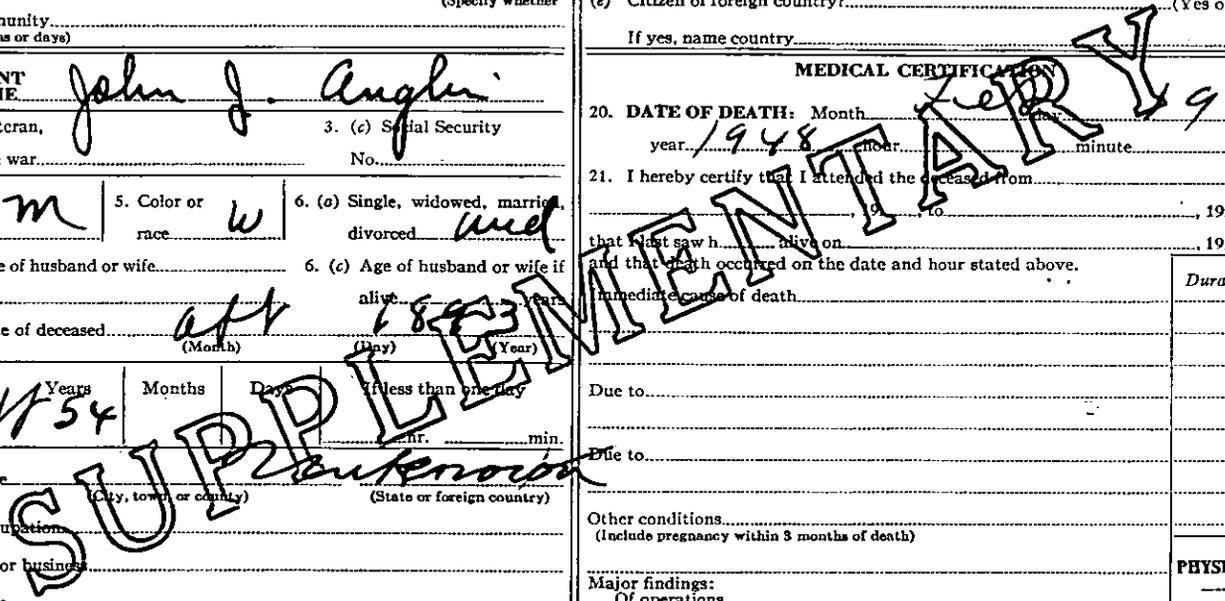
Due to.....
Due to.....
Other conditions..... (Include pregnancy within 3 months of death)

Major findings:
Of operations.....
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?
While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature..... (M. D. or other).....
Address..... Date signed.....

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



MAR 6 1948

1948

S-5995

8906-8