

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. 318 Primary Registration District No. 1003

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: CITY HOSPITAL NO 1
(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

3. (a) PRINT FULL NAME THOMAS DOLAN
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 Oct 6 1869
(Month) (Day) (Year)

8. AGE: Years 79 Months 2 Days 6 If less than one day hr. _____ min. _____

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

10. Usual occupation UNKNOWN

11. Industry or business _____

12. Name UNKNOWN

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

14. Maiden name _____

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

16. (a) Informant W. THOMAS BRADY (b) Address _____

17. (a) BURIAL (b) Date thereof 12-16-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALKARY

18. (a) Signature of funeral director J. J. Kelly

(b) Address 4386 Indlepp

19. (a) DEC 15 1948 (b) J. B. Lasater (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County OSAGE
(c) City or town ST LOUIS (If outside city or town limits, write "RURAL")
(d) Street No. 744 SO 4TH ST. REAR 22 (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12th day Dec year 1948 hour 3 minute 30 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 Bronchopneumonia

Due to Thrombophlebitis

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 Gabriel E. Taylor (M. D. or other) _____

Address 1300 Clark Date signed 12-15-48

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, *Ralph W Hemon*
Licensed Embalmer No. *3791*
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.