

FILED APR 15 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10431**
Registrar's No. **3074**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1008**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY Mad	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS, MO.	
d. FULL NAME OF HOSPITAL OR INSTITUTION CITY INFIRMARY HOSPITAL 0		d. STREET ADDRESS (If rural, give location) 5800 Arsenal 0	

3. NAME OF DECEASED (Type or Print) a. (First) MARY b. (Middle) T c. (Last) MONAHAN			4. DATE OF DEATH (Month) (Day) (Year) MARCH 30 49		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	
8. DATE OF BIRTH 1876		9. AGE (In years last birthday) 72		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Private Homes		11. BIRTHPLACE (State or foreign country) Keokuk, Iowa.	
12. CITIZEN OF WHAT COUNTRY U.S.A.					

13a. FATHER'S NAME John O'Neill		13b. MOTHER'S MAIDEN NAME Catherine Ross		14. NAME OF HUSBAND OR WIFE Francis Monahan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME City Infirmary Record	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION			

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Rupture of Left Ventricle		INTERVAL BETWEEN ONSET AND DEATH Instantan	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTICIPATED CAUSES	
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) Myocardial Infarct 63	
		DUE TO (c) Hypothyroidism 1-20	
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death. Pernicious Anemia 20	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			

21a. ACCIDENT SUICIDE HOME HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **July 7, 1948**, to **March 30, 1949**, that I last saw the deceased alive on **3-30, 1949**, and that death occurred at **1:40 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Victor L. Kray, M.D.		23b. ADDRESS 5600 Arsenal St. St. Louis, Mo		23c. DATE SIGNED March 31, 1949	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE march 31 49		24c. NAME OF CEMETERY OR CREMATORY Catholic	
		24d. LOCATION (City, town, or county) (State) Keokuk, Iowa.			

DATE REC'D BY LOCAL REG. APR 4 1949		REGISTRAR'S SIGNATURE J. B. Sasser		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wm. J. Kraus, Jr. Keokuk, Iowa	
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WRITE PLAINLY—USING 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~~

..... Student Embalmer No.

working under my personal supervision.

Signed..... *H. J. Kraus, Jr.*

Signed.....
Student Embalmer

Licensed Embalmer No. *4578*

P. O. Address *Haskirk, Iowa*

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.