

FILED MAY 10 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **14585**

#26848

318

1003

Registrar's No. **4063**

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>4063</b>			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis, Mo.</b>		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		2069			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis City Hospital #1.</b>				d. STREET ADDRESS (If rural, give location) <b>4935 St. Louis Ave.,</b>					
3. NAME OF DECEASED (Type or Print) a. (First) <b>FRANCIS</b>		b. (Middle) _____		c. (Last) <b>HALLORAN</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>May 2nd, 1950</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>		8. DATE OF BIRTH <b>10/9/1901</b>			
9. AGE (In years last birthday) <b>48</b>		IF UNDER 1 YEAR Months _____		IF UNDER 1 YEAR Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>			10b. KIND OF BUSINESS OR INDUSTRY _____			11. BIRTHPLACE (State or foreign country) <b>St. Louis, Mo.</b>			
12. CITIZEN OF WHAT COUNTRY? _____			13a. FATHER'S NAME <b>Frank H. Halloran</b>		13b. MOTHER'S MAIDEN NAME <b>Cathene O'Connell</b>		14. NAME OF HUSBAND OR WIFE _____		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____			16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Robert Murphy</b>			ADDRESS <b>4935 St. Louis Ave.,</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Pulmonary Tuberculosis - advanced</b>				INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs?</b>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				DUE TO (b) _____				DUE TO (c) _____	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				<b>Danger of left lower leg amputation of left lower leg Rt. Spontaneous pneumothorax - removed</b>				_____	
19a. DATE OF OPERATION _____			19b. MAJOR FINDINGS OF OPERATION _____			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE 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) (Min.) _____		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 <b>3/28/50</b> , to <b>5/2/50</b> , 19____, that I last saw the deceased alive on <b>3/2/50</b> , 19____, and that death occurred at <b>9:00 PM</b> , from the causes and on the date stated above.									
23a. SIGNATURE <b>James A. Hutchinson, M.D.</b> (Degree or title) _____				23b. ADDRESS <b>1515 Lafayette Ave.,</b>		23c. DATE SIGNED <b>5/3/50</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>5/5/50</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>			
DATE REC'D BY LOCAL REG. <b>MAY 4 1950</b>		REGISTRAR'S SIGNATURE _____		25. FUNERAL DIRECTOR'S SIGNATURE <b>Sullivan Brothers Funeral Dir.</b>		ADDRESS <b>1819 S. Grand</b>			

(Licensed Embalmer's Statement on Reverse Side)

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 \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Student Embalmer No. \_\_\_\_\_

Signed \_\_\_\_\_

*Robert L. Brinkman*

Licensed Embalmer No. \_\_\_\_\_

*35-5-3*

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.