

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2738

FILED JAN 19 1954

State File No.

BIRTH NO.

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

Registrar's No. **44**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS Mo		c. CITY OR TOWN ST. LOUIS	
c. LENGTH OF STAY (in this place)		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: 2128 STANSBURY		e. STREET ADDRESS (If rural, give location) 2128 STANSBURY	

3. NAME OF DECEASED (Type or Print)	a. (First) JOHN	b. (Middle) -	c. (Last) EGAN	4. DATE OF DEATH (Month) (Day) (Year) JAN. 2 1954
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH JUNE 24 1887	9. AGE (In years last birthday) 77 6 8	10. MONTHS 7	11. DAYS 10	12. HOURS 11	13. MIN. 15
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED WORKER	10b. KIND OF BUSINESS OR INDUSTRY HAMMER DRY PLATE	11. BIRTHPLACE (City and State or Foreign Country) IRELAND	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME (UNKNOWN) EGAN	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. (If res. give war or dates of service)	17. INFORMANT'S SIGNATURE OR NAME GERTRUDE KLEIN	ADDRESS 2708 ARSENAL
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
<p><i>This does not mean mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i></p>	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		
	ANTECEDENT CAUSES		
	DUE TO (b) Coronary Occlusion DUE TO (c) Coronary Sclerosis		
II. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4201
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22. I hereby certify that I attended the deceased from **19**, to **19**, that I last saw the deceased alive on **11/10/53**, and that death occurred at **11:00 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE Samuel E. Jurek (Describe or title)	23b. ADDRESS 1300 Clark	23c. DATE SIGNED 1/4/54
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE JAN 5 1954	24c. NAME OF CEMETERY OR CREMATORY ST. MATTHEW'S CEM.	24d. LOCATION (City, town, or county) (State) ST. LOUIS Mo
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE Jan 4 1954	25. FUNERAL DIRECTOR'S SIGNATURE Thomas Kulis	ADDRESS 2906 Lewis
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(Licensed Embalmer's Statement on Reverse Side)

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

Cause of death

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..

Student.....
Signature of Student Embalmer

Signed *Samuel C. Hill*.....

Licensed Embalmer No. *434*.....

P. O. Address *2906 G*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.