

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED AUG 2 - 1954

State File No.
6608

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No.

1. PLACE OF DEATH
a. COUNTY _____

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Mo. b. COUNTY _____

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis

c. CITY OR TOWN St. Louis

d. Is residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION DePaul Hospital

e. STREET ADDRESS (If rural, give location) 3829a Sullivan Ave. 2109
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3. NAME OF DECEASED
a. (First) Patrick b. (Middle) J. c. (Last) Eagan

4. DATE OF DEATH (Month) (Day) (Year)
July 15 1954

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH Nov. 4 1895

9. AGE (In years last birthday) 58 IF UNDER 1 YEAR Months Days IF UNDER 1 Hrs. Hours Mins.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter

10b. KIND OF BUSINESS OR INDUSTRY Decorating

11. BIRTHPLACE (City and State or Foreign Country) St. Louis Mo.

12. CITIZEN OF WHAT COUNTRY? _____

13a. FATHER'S NAME Michael Eagan

13b. MOTHER'S MAIDEN NAME Ann Burke

14. NAME OF HUSBAND OR WIFE Deceased

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____

16. SOCIAL SECURITY NO. _____

17. INFORMANT'S SIGNATURE OR NAME ADDRESS
James J. Eagan 9324 Guthrie Ave.

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, asthma, etc. It means the disease, injury, or complication which caused death.
MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____
ANTECEDENT CAUSES _____
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (a) Chronic Myocarditis
DUE TO (c) _____
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. _____
INTERVAL BETWEEN ONSET AND DEATH _____

19a. DATE OF OPERATION _____

19b. MAJOR FINDINGS OF OPERATION _____

20. AUTOPSY? YES NO

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) _____

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from 5/1/54 to 7/15/54, that I last saw the deceased alive on 7/15/54, and that death occurred at 4:10 P.M. from the causes and on the date stated above. 4222

23a. SIGNATURE (Degree or title) Francis J. Miller M.D.

23b. ADDRESS 4414 W. Florence

23c. DATE SIGNED 7/17/54

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 7/19/54

24c. NAME OF CEMETERY OR CREMATORY Calvary

24d. LOCATION (City, town, or county) (State) St. Louis Mo.

DATE REC'D BY LOCAL REG. JUL 19 1954

REGISTRAR'S SIGNATURE J. Carl Smith MD

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Sullivan's 2849 N. Euclid Ave.

No. 300
10.48

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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..

Student.....
Signature of Student Embalmer

Signed..... *Paul A. Wacht*

Licensed Embalmer No. *478*

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