

FILED SEP 29 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-034957  
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 543 Registrar's No. 2472

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Jennings</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Jennings 4138</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>2333 Shannon</b>		Length of stay in lb <b>2 yrs.</b>	d. STREET ADDRESS (If outside, give location) <b>2333 Shannon</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>J.</b> Last <b>Mogan</b>			4. DATE OF DEATH Month <b>Sept.</b> Day <b>23</b> Year <b>1958</b>	
---	--	--	---	--

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 8, 1873</b>	9. AGE (In years last birthday) <b>85</b>	IF UNDER 1 YEAR Months <b>1</b> Days <b>15</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
-----------------------	----------------------------------	---	---	--	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>(Retired) Construction</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Hod Carrier</b>	11. BIRTHPLACE (City and state or country) <b>Galway, Ireland 4</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
--	---	--	---

13a. FATHER'S NAME <b>Peter Mogan</b>	13b. MOTHER'S MAIDEN NAME <b>Mary Walsh</b>	14. NAME OF HUSBAND OR WIFE <b>Bridget</b>
--	--	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Mary Mogan</b> Address <b>3730 Lindell</b>
--	--	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>ARTERIOSCLEROTIC HEART DISEASE 8 yrs.</b>	
	DUE TO (c) <b>4/200</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
---	--

20c. TIME OF INJURY Hour <b></b> Month, Day, Year <b></b> a.m. <b></b> p.m. <b></b>	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b></b>	COUNTY <b></b>	STATE <b></b>
---	---	--	---	----------------	---------------

21. I attended the deceased from <b>June 1958</b> to <b>Sept 23, 58</b> and last saw her alive on <b>Apr 10, 1958</b> Death occurred at <b>9:30 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE <b>John J. Kelly</b> (Degree or title) <b>M.D.</b>	22b. ADDRESS <b>110 Theatre Bldg</b>	22c. DATE SIGNED <b>9/25/58</b>
--	---	------------------------------------

23a. BURIAL OR CREMATION <b>Burial</b>	23b. DATE <b>9/26/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	23d. LOCATION (City, town, or county) <b>St. Louis, Mo.</b>
---	-----------------------------	---	--

24. FUNERAL DIRECTOR <b>Chas. F. Stuart</b> ADDRESS <b>1225 Union</b>	25. DATE RECD. BY LOCAL REG. <b>9-25-58</b>	26. REGISTRAR'S SIGNATURE <b>Richard R. Donham M.D.</b>
--	--	--

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *John S. Demme* .....  
Licensed Embalmer No. *4194* .....  
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.