MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township ..... or Village ..... or City St Louis (No. City Infirmary St. 24 Ward)

Registration District No. 781 File No. 30865

Primary Registration District No. 1003 Registered No. 8795

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Michael Mehan

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Widowed

6 DATE OF BIRTH: Unknown (Month) (Day) 1 (Year)

7 AGE: About 71 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Day Laborer
(b) General nature of industry business, or establishment in which employed (or employer): —

9 BIRTHPLACE (City or town, State or foreign country): Ire

PARENTS

10 NAME OF FATHER: John Mehan

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Ire

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G. M. Mulhall
(Address) 5800 Arsenal St

15 Filed Sep 21 1918 Max C Starkoff Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept 20 (Month) (Day) 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Jan 1 1918, to Sept 20 1918, that I last saw him alive on Sept 20 1918, and that death occurred, on the date stated above, at 12:25 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Gen A

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Senility

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. Edwards Faraele M. D.

9-20 1918 (Address) City Infirmary

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death 1 yrs. 7 mos. 23 ds. In the State 51 yrs. 7 mos. 23 ds.

Where was disease contracted if not at place of death?

Former or usual residence 5800 Arsenal St

19 PLACE OF BURIAL OR REMOVAL: [illegible] DATE OF BURIAL: ....., 191....

20 UNDERTAKER: J Walsh ADDRESS: 5800 Arsenal

Otherwise, if the death is not properly classified, Exact statement of OCCUPATION is very important. Otherwise, if the death is not properly classified, it may be properly classified.

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CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township..... Registration District No..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City..... (NO....., ...St.;.....Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

.....(Month)..... (Day)....., 1.....(Year)

7 AGE

.....yrs.....mos.....ds.

If LESS than 1 day,.....hrs. or.....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work.....

(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER
(City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address).....

15

Filed....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

.....(Month)..... (Day)....., 191.....(Year)

17 I HEREBY CERTIFY, that I attended deceased from

....., 191....., to....., 191.....

that I last saw h.....alive on....., 191.....,

and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY:.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed).....M. D.

....., 191..... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
20 UNDERTAKER	ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.