

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

Do not use this space.

15295

15028-

1. PLACE OF DEATH

County.....

Registration District No. **791**

File No.

Township.....

Primary Registration District No. **1003**

Registered No. **4226**

City **St. Louis Mo** (No. **Mullanphy Hospital**) St. (Ward)

2. FULL NAME

Michael Callahan

(a) Residence. No. **3619 Cora av** St. **6** Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male	4. COLOR OR RACE white	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 13-1863		
7. AGE YEARS 64	MONTHS 9	DAYS 2
IF LESS than 1 day, ____ hrs. or ____ min.		
8. OCCUPATION OF DECEASED		
(a) Trade, profession, or particular kind of work Laborer		
(b) General nature of industry, business, or establishment in which employed (or employer) Quarry		
(c) Name of employer		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **April 15 1928**

17. **3** I HEREBY CERTIFY, That I attended deceased from **April 1**, 19**28**, to **April 5**, 19**28** that I last saw him alive on **4-14**, 19**28**, and that death occurred, on the date stated above, at **7:20 p.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Carcinoma of pancreas and duodenum with obstruction of common duct
(duration) **2 yrs. 4 mos. - da.**

CONTRIBUTORY (SECONDARY) **none**
(duration) **4 1/2 mos. - da.**

18. WHERE WAS DISEASE CONTRACTED
49
IF NOT AT PLACE OF DEATH: **12750**

DID AN OPERATION PRECEDE DEATH? **No.** DATE OF

WAS THERE AN AUTOPSY? **yes**

WHAT TEST CONFIRMED DIAGNOSIS? **Autopsy**
(Signed) **R. ...** M. D.
Apr 17, 1928 (Address) **1117 N Grant**

9. BIRTHPLACE (CITY OR TOWN) **Ireland**
(STATE OR COUNTRY)

10. NAME OF FATHER **Unknown**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Ireland**
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER **Unknown**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Ireland**
(STATE OR COUNTRY)

14. INFORMANT **Mrs. Agnes Chamblin**
(Address) **3619 Cora av**

15. FILED **PR 18 1928** **W. C. Starkloff** REGISTRAR

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Leahway Cemetery** DATE OF BURIAL **April 18 1928**

20. UNDERTAKER **E. J. Schmor** ADDRESS **3125 Lafayette av.**

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

