

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

Do not use this space.

8408

1. PLACE OF DEATH

County..... Registration District No. 102
 Township St. Louis Primary Registration District No. (No. Ernest House 218 S. 4th St.)
 City St. Louis St. _____ Ward _____

File No. _____
 Registered No. 2070
 St. _____ Ward _____

2. FULL NAME

John Monahan
 (a) Residence, No. 218 S. 4th St. St. 25 Ward _____
 (Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Unknown

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
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8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Unknown
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Unknown
 (STATE OR COUNTRY)

10. NAME OF FATHER _____

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

12. MAIDEN NAME OF MOTHER _____

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

14. INFORMANT J.W. Turner
 (Address) 2070 Ernest House

15. FILED FEB 13 1929 REGISTRAR W.C. Frankfort

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2/2 1929

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at 4:10 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
92L (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) HTN. (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? 901B
 IF NOT AT PLACE OF BIRTH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? Pathology
 (Signed) _____ M.D.
2/12 29 (Address) Deputy Coroner

*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 Polters Field DATE OF BURIAL 2/14 1929

20. UNDERTAKER Southern ADDRESS 7315 S. Blvd

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.

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