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

Do not use this space.

12413

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

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

File No. .....

Registered No. 2934

2. FULL NAME Patrick F Monahan

(a) Residence. No. 6262 N Drive St., 11 Ward. St Louis Co. Mo
(Usual place of abode) (If nonresident give city or town and State)

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.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 1st 1859

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	70	2	4	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Chiropractor

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

(c) Name of employer him self

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) St Louis

PARENTS

10. NAME OF FATHER Pat Monahan

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

12. MAIDEN NAME OF MOTHER Mary Stanton

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

14. INFORMANT Elizabeth Monahan
(Address) 6262 North Drive

15. FILED ..... 1929 Max C Starkey
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 5 1929

17. I HEREBY CERTIFY, That I attended deceased from 2-27, 1929, to 3-5, 1929 that I last saw him alive on March 5, 1929, and that death occurred, on the date stated above, at 7 45 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic diffuse nephritis 131
Hypertension 93
Chronic myocarditis 10

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Broncho-pneumonia - uraemia

(duration) yrs. 1 mos. ds.

18. WHERE WAS DISEASE CONTRACTED?

IF NOT AT PLACE OF DEATH? At home

DID AN OPERATION PRECEDE DEATH? no DATE OF .....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Physical exam + laboratory

(Signed) Wm S Becke, M. D

3-6, 1929 (Address) 3720 Washington

*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	DATE OF BURIAL
Calvary	Mar 8 1929
20. UNDERTAKER	ADDRESS
Cullen Kelly	4526 Easton

222
1
15
15

WHITE PERINEY, 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.

Dr Bi[illegible]
3720 Washingto