

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

Do not use this space.

3067

1. PLACE OF DEATH

County Registration District No. **791**
 Town Primary Registration District No. **7003**
 City **St. Louis** (No. **10**) **St. Ann** (No. **10**)
St. Ann (No. **10**) **St. Ann** (No. **10**)

File No.
 Registered No. **556**
 St. Ward)

2. FULL NAME

John L. Bresnahan
 (a) Residence No. **4009 Camelia** St. **9** Ward.

(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

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (Or) WIFE OF **Rose M. Cornick Megnahan**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Sept 15 - 1887**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
42 **04** **11**

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work **Clerk**
 (b) General nature of industry, business, or establishment in which employed (or employer) **Office**
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **Kansas City**
 (STATE OR COUNTRY) **Mo**

10. NAME OF FATHER **Patrick Bresnahan**

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

12. MAIDEN NAME OF MOTHER **Josephine Deane**

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

14. INFORMANT (Address) **Mrs Rose B. Bresnahan 4009 Camelia Ave**

15. FILED **JAN 17 1930** REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Jan 16 30**

17. I HEREBY CERTIFY, That I attended deceased from **Oct 12** 19**29** to **Jan 16** 19**30** that I last saw him alive on **Jan 16** 19**30** and that death occurred, on the date stated above, at **2:30 p.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma Brain
 (duration) yrs. **2** mos. ds.

CONTRIBUTORY (SECONDARY) **Carcinoma Sinus Sarteri**
 (duration) yrs. **6** mos. ds.

18. WHERE WAS DISEASE CONTRACTED **4009 Camelia**
 (CITY OR TOWN) **St. Ann** (STATE OR COUNTRY) **Mo**

DID AN OPERATION PRECEDE DEATH? **yes** DATE OF **12/10/29**
 WAS THERE AN AUTOPSY? **No**

WHAT TEST CONFIRMED DIAGNOSIS? **operative laboratory**
 (Signed) **Arthur S. Smedley** M. D.
1/17 1930 (Address) **2202 University St**

*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 **Calvary** DATE OF BURIAL **1/20 30**

20. UNDERTAKER **Strook & Carroll** ADDRESS **4600 Matt Bodge**

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.

135-1-253

2202 University Ave
East