

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

Do not use this space.

16341

791
1003

File No.
Registered No. **4835**
St. Ward)

1. PLACE OF DEATH

County..... Registration District No.....
Township..... Primary Registration District No.....
City..... (No. *En route City Hospital*)

2. FULL NAME *James Breahan*

(a) Residence No. *1455 Monroe* St., *26* Ward.

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) *Single*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *July 2, 1875*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
55 9 19

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

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

PARENTS
10. NAME OF FATHER *Martin Breahan*
11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Washington D. C.* (STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER *Mary Meyer*
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Washington D. C.* (STATE OR COUNTRY)

14. INFORMANT *William Breahan* (Address) *1455 Monroe St*

15. FILED *22* 19*31* REGISTRAR *J. J. [Signature]*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *April 21* 19*31*

17. *No Physician in Attendance*
I HEREBY CERTIFY, That I attended deceased from _____ 19____, to _____ 19____, and that I last saw h. alive on _____ 19____, and that death occurred, on the date stated above, at *9:30 a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Haemorrhage due to Rupture of Aneurysm of Descending Aorta (non-traumatic)
96 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *96* (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED *Mo*
IF NOT AT PLACE OF DEATH.....

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

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) *John Purley M.D.*
4177. 19 31 (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 *Calvary Cemetery* DATE OF BURIAL *Apr. 24 1931*

20. UNDERTAKER *Goodhart + Goodhart* ADDRESS *2228 St. Louis Ave*

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

