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.

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

JAN 24 1935

Do not use this space.

45088

1. PLACE OF DEATH

County ..... Registration District No. 791 1003

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

City St. Louis (No. Alexian Brosthers Hospital St. ..... Ward)

File No. .....

Registered No. 12245

2. FULL NAME Daniel F. Meehan

(a) Residence, No. 4558 Laclede Ave. St., 12 Ward.
(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	Single.

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 2, 1869.

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	65	10	23	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Salesman

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Standard Varnish.

10. Date deceased last worked at this occupation (month and year) .....

11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Brooklyn. N.Y.

FATHER

13. NAME Lawrence Meehan.

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland.

MOTHER

15. MAIDEN NAME Mary Keaney

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Dont Know.

17. INFORMANT (ADDRESS) 4558 Laclede Ave. Susan C. Keaney

18. BURIAL, CREMATION, OR REMOVAL
PLACE Calvary Cem. DATE Dec. 28, 1934.

19. UNDERTAKER (ADDRESS) J. H. Gebken L & U Co. 2842 Meramec St.

20. FILED DEC 27 1934 19 Jos F. Bredeck Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec. 25, 1934

22. I HEREBY CERTIFY, That I attended deceased from May 1st, 1934, to Dec 24, 1934

I last saw him alive on Dec-24, 1934. Death is said to have occurred on the date stated above, at 7:00 A. m.

The principal cause of death and related causes of importance were as follows:

Cerebral Hemorrhage

Date of onset

Other contributory causes of importance: Arterio Sclerosis

Name of operation ..... Date of .....

What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19.....

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) Joseph L. Ferris M.D.

(Address) 4809 Virginia

1/26/34