

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.

1939 MAR 13
 Div. No. 1003

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

4495
 Do not use this space.

1. PLACE OF DEATH
 (a) County..... Registration District No..... **791**
 (b) Township..... Primary Registration District No..... **1003**
 (c) City **ST. LOUIS** (d) Street No. **ST. JOHN'S HOSPITAL** Registered No. **1188**
 (If death occurred in Hospital of Institution, state its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **JOHN H. CALLAHAN**
 (a) Residence, No. **5321 REBER PLADE** St. **13** (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS
 3. SEX **M.** 4. COLOR OR RACE **W.** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **MARRIED.**
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **FRANCES M. CALLAHAN**
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Jan. 1, 1877**
 7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
62 1 3
OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **adjuster**
 9. Industry or business in which work was done, as saw mill, bank, etc. **Telephone Co.**
 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) ST. LOUIS, MO.
FATHER
 13. NAME **DAN CALLAHAN**
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **IRELAND**
MOTHER
 15. MAIDEN NAME **CATHERINE DANIELS**
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **IRELAND**
 17. INFORMANT (ADDRESS) **Frances M. Callahan, 5321 Reber Place.**
 18. BURIAL, CREMATION, OR REMOVAL PLACE **CALVARY CEMETERY** DATE **2/7/39** 19.....
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) **OSCAR J. HOFFMEISTER, 4016 Chippewa St.**
 20. FILED **FEB 6 1939** **J. D. Bricker** Local Registrar.

MEDICAL CERTIFICATE OF DEATH
 21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Feb. 4, 1939**
 22. I HEREBY CERTIFY, That I attended deceased from **Feb. 4, 1939, to Feb. 4, 1939**
 I last saw him alive on **Feb. 4, 1939.** Death is said to have occurred on the date stated above, at **5:29 p.m.**
 The principal cause of death and related causes of importance were as follows:
Myocardial infarction
Arteriosclerosis
 Date of onset
 Other contributory causes of importance:
Arteriosclerosis
 Name of operation..... Date of.....
 What test confirmed diagnosis?..... Was there an autopsy?.....
 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) **Walter A. Dell**, M. D.
 (Address) **7346 Manchester, Maplewood, Mo.**

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *Edwin H. Levinger*

Licensed Embalmer No. *4049*

P. O. Address *4216 Chippewa*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.