

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
AUG 11 1939
MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **23565**
Registrar's No. **5838**

Registration District No. **791-1008** Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis, Mo
(c) Name of hospital or institution: 1817 South Broadway 2
(d) Length of stay: 40 yr.
In this community _____ years, months or days (Specify whether _____)

8. (a) PRINT FULL NAME Anna Vincent Grogan
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Feb 16 1877
(Month) (Day) (Year)

8. AGE: Years 62 Months 4 Days 13 If less than one day _____ hr. _____ min.

9. Birthplace Pittsburg Penn
(City, town, or county) (State or foreign country)

10. Usual occupation Handwork - Retired

11. Industry or business _____

12. Name Thomas Grogan

13. Birthplace unknown Ireland
(City, town, or county) (State or foreign country)

14. Maiden name Mary Cassey

15. Birthplace unknown Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mabel Bentrup

(b) Address 1817 S. Broadway

17. (a) Burial (b) Date thereof July 3, 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Carmel Cem.

18. (a) Signature of funeral director Wesley Thedefeld

(b) Address 455-91 9th St. E. St. Louis

19. (a) 1111 1 1939 (b) J. F. Redeker
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County _____
(c) City or town St. Louis **23**
(d) Street No. 1817 South Broadway
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month June day 29 year 1939 hour 10 minute 45 P. M.
21. I hereby certify that I attended the deceased from June 15, 1939, to June 29, 1939, that I last saw her alive on June 29, 1939, and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Apoplexy Duration 14 days
Due to Arterio-sclerosis
Due to _____

Other conditions (Include pregnancy within 4 months of death) _____

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (a) Means of injury _____

23. Signature Wm. Cannon (M. D. or other) 301

Address 2014 Jefferson Date signed June 13 1939

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.....

working under my personal supervision.

Registered Apprentice No.....

Signed.....

Albert G. Hoffe

Licensed Embalmer No. *2971*

P. O. Address.....

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.