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

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

REC'D NOV 13 1939 791

State File No. 33978

Registration District No. 1003 Primary Registration District No. _____ Registrar's No. 8516

1. PLACE OF DEATH:

(a) County 1

(b) City or town St Louis Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Dee Paul Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 Month
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 1

(a) State Mo (b) County _____ 26

(c) City or town St Louis Mo
(If outside city or town limits, write "RURAL")

(d) Street No. 3921 N 19 Th Str
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Michael Ralph Lanigan 525

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 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 Aug. (Month) 31 St (Day) 1939 (Year)

8. AGE: Years | Months 1 -- | Days 3 | If less than one day _____ hr. _____ min.

9. Birthplace St Louis Mo (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

FATHER
12. Name Ralph Lanigan
13. Birthplace St Louis Mo (City, town, or county) _____ (State or foreign country)

MOTHER
14. Maiden name Catherine Straub
15. Birthplace St Louis Mo (City, town, or county) _____ (State or foreign country)

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16. (a) Informant's own signature Ralph Lanigan
(b) Address 3921 N. 19 Th Str

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 5 Th 1939 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cem.

18. (a) Signature of funeral director Edward Koch
(b) Address 3516 N 14 Str

19. (a) OCT 4 1939 (Date received local registrar) (b) J F Bulock (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 3 year 1939 hour 7 oc minute P M.

21. I hereby certify that I attended the deceased from 8-31-39 _____, 19__, to 10-3, 1939 that I last saw him alive on 10-3, 1939 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Acute osteomyelitis	14 days
Due to infection	
non tubercular	
Due to	
Other conditions Septicemia (Include pregnancy within 3 months of death)	10 days

Major findings:
Of operations pus
Of autopsy same

PHYSICIAN
Underline the cause to which death should be charged statistically

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

23. Signature Walter H Spoenemann (M.D. or other) 1
Address 1506 St Louis Date signed 10-4-39

(Licensed Embalmer's Statement on Reverse Side)

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 Harry J Schumacher

Licensed Embalmer No. 2679

P. O. Address 732 Lemay

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

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