

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 34284
Registrar's No. 8822

Registration District No. 1701 Primary Registration District No. _____

1. PLACE OF DEATH: 1003
 (a) County _____
 (b) City or town St. Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
4925 Loughborough
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)
 In this community Life
 years, months or days

3. (a) PRINT FULL NAME James J. Breen 659
 3. (b) If veteran, name war: ----- 3. (c) Social Security No. 488-07-7630

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Sophia
 6. (c) Age of husband or wife if alive 58 years
 7. Birth date of deceased December 18, 1876
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>62</u>	<u>9</u>	<u>27</u>	_____ hr. _____ min.

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

10. Usual occupation Factory worker

11. Industry or business Hager Hinge Company

MOTHER FATHER
 12. Name James Breen
 18. Birthplace Ireland
 (City, town, or county) (State or foreign country)
 14. Maiden name Unknown
 15. Birthplace Unknown
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Sophia Breen
 (b) Address 4925 Loughborough
 17. (a) Burial (b) Date thereof 10/17/39
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sunset
 18. (a) Signature of funeral director Wacker-Waldede
 (b) Address 333 Broadway
 19. (a) OCT 16 1939 (b) _____
 (Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County 1
 (c) City or town St. Louis (If outside city or town limits, write "RURAL") 2
 (d) Street No. 4925 Loughborough (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 14
 year 1939 hour 5 minute _____ A. M.
 21. I hereby certify that I attended the deceased from 8-16
 1939, to 10-14, 1939;
 that I last saw him alive on 10-6, 1939;
 and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration 6 mo.
Carcinoma of lungs
 Due to Secondary to
carcinoma of mouth
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)
 Major findings: _____
 Of operations _____
 Of autopsy _____
 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? _____

While at work _____ (Specify type of place) (e) Means of injury _____
 23. Signature J. Jones (M. D. or other) MD
 Address 3616 S. Swedy Date signed 10-16

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MARGIN RESERVED FOR BINDING
 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.

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.....

Robert Wheeler

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Robert Wheeler

Licensed Embalmer No. *2128*

P. O. Address *St. Louis, Mo.*

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.