

Registration District No. **791**

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH: **1003**

FILED FEB 17 1940

USUAL RESIDENCE OF DECEASED:

(a) County **St. Louis**  
(b) City or town **St. Louis**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution **3929 N. Markey St.**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

(a) State **Missouri** (b) County \_\_\_\_\_  
(c) City or town **St. Louis**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **3929 N. Market St.**  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME **Catherine Dolan, 450**  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. **None**

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **Jan.** day **17**  
year **1940** hour **1** minute **25** P. M.

4. Sex **Female** 5. Color or race **White**  
6. (a) Single, widowed, married, divorced **Married**  
6. (b) Name of husband or wife **Thomas P. Dolan**  
6. (c) Age of husband or wife if alive **19** years **1882**  
7. Birth date of deceased: **April** (Month) **19** (Day) **1882** (Year)

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

8. AGE: Years **57** Months **8** Days **28**  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death  
Due to **Permanent Occlusion**  
Due to **Coronary Sclerosis**  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

9. Birthplace **County Limrick Ireland**  
(City, town, or county) (State or foreign country)  
10. Usual occupation **At Home**

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

MOTHER FATHER { 12. Name **Thomas Sheehan**  
13. Birthplace **Ireland**  
14. Maiden name **Julia Dorgan**  
15. Birthplace **Ireland**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Thomas Dolan**  
(b) Address **3929 N. Market St.**  
17. (a) **Burial** (b) Date thereof **1-19-40**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Calvary Cemetery**  
**Cullinane Brothers**  
18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address **1710 N. Grand Blvd.**  
19. (a) **JAN 18 1940** (b) \_\_\_\_\_  
(Date received local registrar) (Signature of registrar)

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 injury) \_\_\_\_\_  
Means of injury **4**  
23. Signature **Walter Perry** (M. D. or other) \_\_\_\_\_  
Address **Deputy Coroner** Date signed **1-19-40**

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

**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.....

*Fred Frick*

Licensed Embalmer No. *3186*

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.**