

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 584
Registrar's No. 584

Registration District No. 791 Primary Registration District No. _____

1. PLACE OF DEATH: 1008 FILED FEB 17 1940
(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:
5130A Wells Ave 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 25yrs
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County _____
(c) City or town St. Louis 6
(If outside city or town limits, write "RURAL")
(d) Street No. 5130A Wells
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 25yrs years.

3. (a) PRINT FULL NAME John P. Geoghegan 7 25
(b) If veteran, name war Nil
(c) Social Security No. Nil

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan day 19th.
year 1940 hour _____ minute 11:45AM M.
21. I hereby certify that I attended the deceased from 3-22-37
1937 to 1-19 1940
that I last saw him in alive on 1-19 1940
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Margaret Geoghegan 6. (c) Age of husband or wife if alive 50 years
7. Birth date of deceased Nov 14th. 1890
(Month) (Day) (Year)

Immediate cause of death Unknown endocarditis
Due to Parkinson's syndrome
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: _____
Of operations _____
Of autopsy _____

8. AGE: Years 52 Months 2 Days 5 If less than one day
hr. _____ min. _____

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

10. Usual occupation Letter Carrier

11. Industry or business U.S. Government

MOTHER FATHER { 12. Name Michael Geoghegan

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

14. Maiden name Hannigan Bynnes

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

16. (a) Informant's own signature Margaret Geoghegan

(b) Address 5130A Wells Ave

17. (a) Burial (b) Date thereof 1/22/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemt

18. (a) Signature of funeral director Harrigan & Sheahan Und Co

(b) Address 4415 Washington Blvd.

19. (a) JAN 21 1940 (b) J.P. [Signature]
(Date received local registrar) (Embalmer's signature)

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 [Signature] (M. D. or other)
Address 5074 Union Date signed 1-19-40

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

N. B. - Every item of information should be carefully supplied. AGH 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.

Dr. H. Klein
71 Madison Ave

See affidavit # 243 in mine file

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..... *Homer H. Witt*

Licensed Embalmer No..... *3882*

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.

S. No. 2
-11-10-39
3-17-39
X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 584

1. PLACE OF DEATH:

(a) County _____
(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution 5130^a Wells **SUPPLY**
(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 _____

8. (a) PRINT FULL NAME John P. Geoghegan

3. (b) If veteran, name war _____ 8. (f) Social Security No. _____

4. Sex Male 5. Color of race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 11 14 1887
(Month) (Day) (Year)

8. AGE: Years 52 Months 2 Days 5 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant Margaret Geoghegan

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 3-14-40 (b) J. F. Bradic
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. 2428 (If rural, give location) _____
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 19
year 1940 hour _____ minute _____ M.

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.

Immediate cause of death _____

Duration

Due to _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

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.....

Licensed Embalmer No.....

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.