

791

1003

Registration District No. Primary Registration District No. Registrar's No.

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

1. PLACE OF DEATH:

(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:
5131 Minerva Ave
(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

3. (a) PRINT FULL NAME Joseph E. Hennigan

8. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex Male 5. Color or race Wh 6. (a) Single, widowed, married, divorced

6. (b) Name of husband or wife Ruth Trason 6. (c) Age of husband or wife if alive 47 years

7. Birth date of deceased May 20-1907
(Month) (Day) (Year)

8. AGE: Years 67 Months 10 Days 12 If less than one day _____ hr _____ min.

9. Birthplace Lumpkin Co. Carolina
(City, town, or county) (State or foreign country)

10. Usual occupation Fireman

11. Industry or business Streets, Sewer Dept

12. Name John Hennigan

13. Birthplace Lumpkin Co. Carolina
(City, town, or county) (State or foreign country)

14. Maiden name Margaret Russell

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

16. (a) Informant Ruth Trason Hennigan

(b) Address 5131 Minerva

17. (a) Burial (b) Date thereof Mar 26-1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Wesley Stuart

(b) Address 1225 Union Blvd

19. (a) MAR 25 1948 (b) J. Budick
(Date received local registrar) (Registrar's signature)

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. 5131 Minerva
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 22
year 1948 hour 10.20 minute _____ P. M.

21. I hereby certify that I attended the deceased from July 1st
1936 to March 22, 1948;
that I last saw him alive on March 18, 1948;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral thrombosis
Due to hypertension
Due to _____

Other conditions Chronic Myocarditis
(Include pregnancy within 3 months of death)
Tuberculosis (4 yrs.)

Major findings _____
Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:
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. P. Murch (M. D. or other) _____
Address 1306 Academy Date signed 3/27/48

Duration

4 days

5 years

4 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

920

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 Gay W Wilkinson

Licensed Embalmer No. 3575

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 9294
Registrar's No. 2777-

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 101209
101791

Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(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:

(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ (Specify whether)
years, months or days

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME Joseph E. Hennigan

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased. (Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

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

14. Maiden name _____ (State or foreign country)

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 5-6-40 (b) J. J. Bredek (Registrar's signature)

19. MEDICAL CERTIFICATION
20. DATE OF DEATH Month Mar. day 23 year 40
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
Cerebral thrombosis
Hypertension
Due to 430

Due to Chr. Myocarditis
Paralysis of head & eyes

Other conditions (Include pregnancy within 3 months of death)
a heart stroke which
Major findings:
operated
stroke on July 1, 1936
It affected half of her
back

Duration
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. R. Macho (M. D. or other)

Address _____ Date signed _____

SUPPLEMENTARY

1940

S-9294