

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

12330

Registration District No. 784

Primary Registration District No. 104

State File No. \_\_\_\_\_

Registrar's No. 641

1. PLACE OF DEATH

(a) County St. Louis  
(b) City or town FERGUSON MISSOURI  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
DR. ROY JOHNSON HOSPITAL  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 HR.  
(Specify whether  
In this community 22 YRS.  
years, months or days) 0/0/1

8. (a) PRINT FULL NAME FAHEY JOHN J.

8. (b) If veteran, name war NONE 8. (c) Social Security No. NONE

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED  
6. (b) Name of husband or wife KATHERINE FAHEY 6. (c) Age of husband or wife if alive 56 years  
7. Birth date of deceased OCTOBER 18<sup>TH</sup> 1878  
(Month) (Day) (Year)

8. AGE: Years 61 Months 5 Days 13 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation FORMERLY JUSTICE OF PEACE

MOTHER { 11. Industry or business OF PEACE  
FATHER { 12. Name JOHN FAHEY  
13. Birthplace IRELAND  
14. Maiden name MARY COOGAN  
15. Birthplace IRELAND  
(City, town, or county) (State or foreign country)

16. (a) Informant Katherine Fahey

(b) Address 429 N. Elizabeth Ave  
17. (a) BURIAL (b) Date thereof APRIL 3<sup>RD</sup> 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY CEMETARY 707

18. (a) Signature of funeral director Brookland  
(b) Address 1827 Logan

19. (a) APR - 1 1940 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI, (b) County St. Louis  
(c) City or town FERGUSON MO.  
(If outside city or town limits, write "RURAL")  
(d) Street No. 429 NORTH, ELIZABETH AVE  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? ALL LIFE years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 31  
year 1940 hour 11 minute 0 A. M.

21. I hereby certify that I attended the deceased from 2-28-1940 to 3-31-1940  
that I last saw him alive on 3-31-1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis Duration 30 days

Due to \_\_\_\_\_  
Due to Chor Myocarditis 1935

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations [Signature] PHYSICIAN  
Of autopsy none  
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)  
(e) Means of injury \_\_\_\_\_

23. Signature Roy Johnson (M. D. or other) \_\_\_\_\_  
Address Ferguson Mo Date signed 4-1-40

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

*Gary 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.