

**FILED** AUG 25 1940 791  
Registration District No. **1003**

Primary Registration District No. **1003**

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 2413 Macklind Ave.  
(If not in hospital or institution, write street number or location) 2

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_

(c) City or town Mo. St. Louis 13  
(If outside city or town limits, write "RURAL")

(d) Street No. 2413 Macklind Ave.  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Clarence H. Geary 600

3. (b) If veteran, name war World War

3. (c) Social Security No. 482-20-1965

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Anna Geary

6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased Oct. 2nd 1889  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>50</u>	<u>9</u>	<u>22</u>	_____ hr. _____ min.

9. Birthplace Mo. 0  
(City, town, or county) (State or foreign country)

10. Usual occupation Machinist

11. Industry or business American Type Foundry Co.

12. Name John Thomas Geary

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

14. Maiden name Unknown

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

16. (a) Informant Mrs. Anna Geary

(b) Address 2413 Macklind Ave.

17. (a) Removal (b) Date thereof 7-25-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kansas City Mo.

18. (a) Signature of funeral director Kriegshauser Mortuaries

(b) Address 4228 So. Kingshighway

19. (a) Duty 25-40 (b) J. F. Bredick  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 24th  
year 1940 hour 5 A.M. minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from July 23, 1940, to July 24, 1940;  
that I last saw him alive on July 24, 1940;  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Acute Indigestion caused by improper diet

(Include pregnancy within 3 months of death)

Major findings: None

Of operations \_\_\_\_\_

Of autopsy No

Duration 30 minutes

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) No

(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) \_\_\_\_\_

While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature James R. Blumock (M. D. \_\_\_\_\_)

Address 2608 S. Kingshighway Date signed 7/24/40

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

*Reinhold K. Lehmann*

Licensed Embalmer No.

*3395*

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, fact should be so stated above.**