

No. 2
1-10-3
17-39
X21492

SEP 25 1940

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **7240**

1. PLACE OF DEATH:

(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:
St. Anthony's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3-Weeks**
(Specify whether
In this community _____
years, months or days)

9. (a) PRINT FULL NAME **Michael J. Holloran 465**

8. (b) If veteran, name war **None** 8. (c) Social Security No. **488-10-5592**

4. Sex **M.** 5. Color or race **W.** 6. (a) Single, widowed, married, divorced **W.**

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

7. Birth date of deceased **Aug. 18, 1881**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
59 0 8 hr. min.

9. Birthplace **St. Louis Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Salesman**

11. Industry or business **Boyd's**

12. Name **Patrick Holloran**

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

14. Maiden name **Bridget Unknown**

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

16. (a) Informant **Robert X. Holloran**
(b) Address **1919 S. Grand Blvd.**

17. (a) **Burial** (b) Date thereof **8-29-1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary**

18. (a) Signature of funeral director **Arthur J. Donnelly**
(b) Address **3840 Lindell Blvd.**

19. (a) **AUG 28 1940** (b) **J. J. Bredebeck**
(Occurrence of local health officer) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County _____
(c) City or town **St. Louis 17**
(If outside city or town limits, write "RURAL")
(d) Street No. **1919 S. Grand Blvd.**
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug.** day **26th.**,
year **1940** hour **6** minute **P.** M.

21. I hereby certify that I attended the deceased from **August 9**
19**40**, to **Aug 26, 1940**
that I last saw him alive on **Aug 26, 1940**
and that death occurred on the date and hour stated above.

Immediate cause of death: **Pulmonary Embolus - no pneumonia**

Due to **Cause unknown**

Due to **111a**

Other conditions (Include pregnancy within 3 months of death)

Major findings: **Hypertrophied prostate - removed**
Of autopsy _____

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) Manner of injury _____

23. Signature **Elmer E. Estlin** (M. D. or other) _____
Address **111 S. Paul Brown Bldg.** - Date signed **8/27/40**

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

2605 GRANDVIEW AVE.

E. Johnston

Paul R. Bell
LH 49 57

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 W Van Matre
Licensed Embalmer No. 2825
P. O. Address 4340 Lafayette

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. 27344

Registrar's No. 2240

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County.....
(b) City or town.....
(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.....
In this community..... (Specify whether
years, months or days)

3. (a) PRINT FULL NAME.....
Michael J. Halloran

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

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

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

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.....

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.....

(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) (Date received local registrar) 12-9-40 (b) (Registrar's signature) J. T. Bredeck

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.

20. DATE OF DEATH.....
Month..... day..... year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19..... to..... 19.....
that I last saw h..... alive on..... 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 operation.....

Of autopsy.....

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.....

SUPPLEMENTARY

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

MOORE

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

