

Registration District No. 791

Primary Registration District No.

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:
2515 Mullanphy St
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community Life
years, months or days)

8. (a) PRINT FULL NAME Ellen Frances McLoughlin

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

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

6. (b) Name of husband or wife John 6. (c) Age of husband or wife if alive Dec'd years

7. Birth date of deceased June 21st 1853
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
87 2 23 hr. min.

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

10. Usual occupation None

11. Industry or business At Home

12. Name Samuel Sargent

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

14. Maiden name Mary Doyle

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

16. (a) Informant Elizabeth Kane

(b) Address 2515 Mullanphy St

17. (a) Burial (b) Date thereof 9/14/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemt

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

(b) Address 4415 Washington Blvd

19. (a) SEP 16 1940 (b) J.P. Reddeck
(Date received by local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County _____
(c) City or town St. Louis 26
(If outside city or town limits, write "RURAL")
(d) Street No. 2515 Mullanphy St
(If rural, give location)
(e) If foreign born, how long in U. S. A.? Life years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 14
year 1940 hour 3:00A.M. minute _____ M.

21. I hereby certify that I attended the deceased from Sept 14 1940 to Sept 14 1940
that I last saw her alive on Sept 13 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis (non complicated) with Ast. Scler.
Due to _____

Due to _____
Other conditions 930
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy no

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) Means of injury _____

23. Signature J.P. Reddeck (M. D. or other) _____
Address 4901 Easton Date signed 9/14/40

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

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

4901 Canton Blvd
1-2180

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 _____

Stanley H. Dixon

Registered Apprentice No. 214

working under my personal supervision.

Signed

Albert G. Koffe

Licensed Embalmer No. 2971

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.