

Registration District No.

Primary Registration District No. **1003**

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
Emmalee City Hospital #13
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community **69 years 10 mos.**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **Timothy Horgan**

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

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

6. (b) Name of husband or wife **Mary Horgan** 6. (c) Age of husband or wife if alive **70** years

7. Birth date of deceased **Nov. 17, 1870**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	69	10	0	hr. min.

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

10. Usual occupation **Common laborer**

11. Industry or business **City Park Dep't.**

MOTHER FATHER

12. Name **Thomas Horgan**

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

14. Maiden name **Katherine McGolgan**

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

16. (a) Informant **Nellie Toomey**
(b) Address **5737 Maffitt Ave**

17. (a) **Burial** (b) Date thereof **Sept. 20, 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director **Woodhart Woodhart**
(b) Address **2228 St. Louis Ave**

19. (a) **SEP 19 1940** (b) **J.F. Woodhart**
(Date received local registrar) (Signature)

(Licensed Embalmer's Statement on Reverse Side)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County.....
(c) City or town **St. Louis** **21**
(If outside city or town limits, write "RURAL")
(d) Street No. **1916 Division St**
(If rural, give location)
(e) If foreign born, how long in U. S. A.?..... years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **17**
year **1940** hour **18:29** minute **A.** M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....
that I last saw h..... alive on....., 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Apoplexy**

Due to.....

Due to.....

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

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) (a) Means of injury **5**

23. Signature **Joseph M. Finn** (M.D. or other)

Address **Resident Doctor** Date signed **9/19/40**

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

MOTHER FATHER

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

Charles Goodhart

Licensed Embalmer No. 2777

P. O. Address *H. L. Over Mo*

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.