

NOV 16 1940

791

Registration District No.

Primary Registration District No.

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

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis Mo
(c) Name of hospital or institution: Missouri Pacific Hospital
(d) Length of stay: In hospital or institution 3 weeks
In this community 60 years

3. (a) PRINT FULL NAME FRANK THOS. KILLOREN

3. (b) If veteran, name war no 3. (c) Social Security No. 702-14-4210

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

(b) Name of husband or wife Margaret Killoren 6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased May 14 1870

8. AGE: Years 70 Months 4 Days 15 hr. _____ min. _____

9. Birthplace New Haven Mo

10. Usual occupation Railroad Conductor

11. Industry or business Missouri Pacific R.R.

12. Name Owen Killoren

13. Birthplace Ireland

14. Maiden name Elizabeth

15. Birthplace Pa

16. (a) Informant Margaret Killoren

(b) Address 5006 Heath

17. (a) Burial (b) Date thereof Oct 2 1940

(c) Place: burial or cremation New Haven Mo

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

(b) Address 4217 St. Louis Ave

19. (a) OCT 1 1940 (b) J. J. ...

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County _____
(c) City or town St. Louis 14
(d) Street No. 5006 Heath
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 30 year 40 hour 5 minute 55 A.M.

21. I hereby certify that I attended the deceased from 8-12 1940 to 9-30 1940 that I last saw him alive on 9-30-40 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary of Scurvy

Due to _____
Due to _____

Other conditions 174
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____

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) Means of injury 1

23. Signature J. M. Boyd Date signed 9-30-40

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 *Jos. A. Howard*

Licensed Embalmer No. 3941

P. O. Address 4212 ST. LOUIS AVE.

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.