

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

36320

State File No. \_\_\_\_\_

ED NOV 25 1940 84

Primary Registration District No. 106

Registrar's No. 1922

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town Kirkwood, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Louis Marine  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 67 days  
(Specify whether  
In this community Unknown  
years, months or days)

3. (a) PRINT FULL NAME Joseph Stephen Callaghan

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

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

6. (b) Name of husband or wife X 6. (c) Age of husband or wife if alive X years

7. Birth date of deceased August 3rd 1904  
(Month) (Day) (Year)

8. AGE: Years 36 Months 2 Days 3 If less than one day hr. \_\_\_\_\_ min.

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

10. Usual occupation Wheelman

11. Industry or business Str. Galloway

12. Name Stephen Callaghan

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

14. Maiden name Annie Murray

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

16. (a) Informant Clinical records of patient

(b) Address on entry into St. Louis Marine Hosp

17. (a) BURIAL (b) Date thereof 10-12-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation ST. MATTHEW'S CEM.

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

(b) Address 7814 S. Broadway

19. (a) OCT 11 1940 (b) St. Louis Marine Hospital  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State New York (b) County \_\_\_\_\_  
(c) City or town Newfield  
(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. 33 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 6th  
year 1940 hour Four minute 0 P.M.

21. I hereby certify that I attended the deceased from July 31,  
1940, to October 6th, 1940

that I last saw him alive on Oct. 5, 1940, 19\_\_\_\_,  
and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis, pulmonary  
chronic, far advanced Duration Unknown

Due to 23

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

Other conditions Otitis media, chr. suppurative 5 mo.  
(Include pregnancy within 3 months of death) bilateral

Major findings:  
Of operations none

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) No

(b) Date of occurrence No

(c) Where did injury occur? No.

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(City or town) (County) (State)

While at work? (Specify type of place) (e) Means of injury

23. Signature C. Hoffmeister (M. D. or other) 1

Address St. Louis Marine Hospital Date signed 10/7/40

AUG 7 1947

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

*James C. Hoffmeister*

Licensed Embalmer No. 3821

P. O. Address 7814 S. Broad

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.