

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **40890**

Registration District No. **7911**

Primary Registration District No. **1003**

Registrar's No. **10664**

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: Christian Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME NELLIE HANNEGAN.

3. (b) If veteran, name war None 3. (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 D. Hannegan 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Jan. 5, 1879
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
61 11 19 hr. _____ min.

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

10. Usual occupation At. Home

11. Industry or business _____

12. Name John T. Phelan

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

14. Maiden name Johanna Murphy

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

16. (a) Informant Mrs. Margaret Jenkins

(b) Address 4561 Adelaide Ave.

17. (a) Burial (b) Date thereof 12/28/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

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

(b) Address 2117 E. Grand Blvd.

19. (a) DEC 26 1940 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

Missouri
(a) State St. Louis (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4561 Adelaide Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 24
year 1940 hour 7 minute 15 P.M.

21. I hereby certify that I attended the deceased from Dec 17 1940 to Dec 24 1940
that I last saw her alive on Dec 24 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage left

Due to Hypertension

Due to _____

Other conditions (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 _____

23. Signature [Signature] (M. D. or other) 340

Address 4005 W. Flamingo Date signed 12-26-40

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

FATHER
MOTHER

4005-1 W. Skinner
Apr. 12-50
Apr. Mar. 9722

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 Frank A. Payne
Licensed Embalmer No. 3041
P. O. Address 2117 E. Lee

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.