

No. 2  
13-40  
17-39  
X23159

FILED APR 21 1941

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

9229  
State File No.  
2639  
Registrar's No.

Registration District No. 791  
Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County \_\_\_\_\_  
(b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Louis City Hospital #1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 10 Days  
(Specify whether \_\_\_\_\_)  
In this community 50vrs.  
years, months or days)

3. (a) PRINT FULL NAME John Leary  
3. (b) If veteran, Unknown 3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widower  
6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive Unknown years  
7. Birth date of deceased December 15, 1866  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
74 2 12 \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Nil.

11. Industry or business Nil.

MOTHER FATHER { 12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Ann Morrison  
(b) Address St. Louis City Hospital #1.

17. (a) \_\_\_\_\_ (b) Date thereof 3-8-41  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Washington

18. (a) Signature of funeral director W. R. ...  
(b) Address 3rd St. ...

19. (a) MAR 25 1941 (b) J. H. ...  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County XX  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL") 17  
(d) Street No. No Home (If rural, give location) 0  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 6,  
year 1941 hour 5:15 minute A. M.  
21. I hereby certify that I attended the deceased from February  
28, 1941 to March 6, 1941  
that I last saw h. im alive on March 6, 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Pancreas  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions 55  
(Include pregnancy within 3 months of death)  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy 12  
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 J. H. ... M.D. (M. D. or other) \_\_\_\_\_  
Address 156 Lafayette Avenue, Date signed 3/5/41

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

5-70

**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.....

Licensed Embalmer No.....

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, fact should be so stated above.**