. No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 26156

FILED AUG 8 1941

Registration District No. 1824 Primary Registration District No. 111 Registrar's No. 1460

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

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1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Richmond Heights
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Mary's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis 96
(c) City or town Kirkwood 4
(If outside city or town limits, write "RURAL")
(d) Street No. U.S. Marine Hospital 3
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 1 years.

3. (a) PRINT FULL NAME Josephine Crahan
3. (b) If veteran, name war No.
3. (c) Social Security No. None
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Thos. F.
6. (c) Age of husband or wife if alive 30 years
7. Birth date of deceased Jan. (Month) 6 (Day) 1911 (Year)

8. AGE: Years 30 Months 6 Days 4 If less than one day hr. min.

9. Birthplace Westernport (City, town, or county) Md. (State or foreign country)
10. Usual occupation Housewife
11. Industry or business

MOTHER FATHER
12. Name Michael Daley
13. Birthplace (City, town, or county) Md. (State or foreign country)
14. Maiden name Clara Kelly
15. Birthplace (City, town, or county) Md. (State or foreign country)

16. (a) Informant Dr. T. F. Crahan
(b) Address U.S. Marine Hospital
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 7/11/41 (Month) (Day) (Year)
(c) Place: burial or cremation Westernport, Md.
18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Ave.
19. (a) JUL 11 1941 (Date received by local registrar) (b) R. Meyer M.D. Dr. (Registrar's signature)
Jo/3.0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 10th year 1941 hour 11 minute P M.
21. I hereby certify that I attended the deceased from May 30, 1941, to July 10, 1941, that I last saw her alive on July 10, 1941 and that death occurred on the date and hour stated above.

Immediate cause of death Shock — Duration
Due to Premature separation of placenta
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations Premature separation of placenta
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature T. Nelson Hoge (M. D. or other)
Address 330 Metropolitan Bldg. Date signed 7-11-41

(Licensed Embalmer's Statement on Reverse Side)

146 Pr

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 Albert H. Hoppe

Licensed Embalmer No. 1861

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.

S. No. 2B
0—4-25-41
I X27852

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. Primary Registration District No. Registrar's No. 1460

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Rch. Hts. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Mary's (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)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town (If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Josephine Crahan

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife

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

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 30 Months Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 10-41 year hour 11 minute P 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 Shock Premature separation of placenta

Due to Child died during labor-Born 11.01PM

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

1460

Duration

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

S-26156