

FILED OCT 18 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 30413
Registrar's No. 7752

Registration District No. 791

Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County ST LOUIS MO

(b) City or town ST LOUIS MO
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
4625 GREER AVE
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 (Specify whether
years, months or days)

3. (a) PRINT FULL NAME KATHERINE CHARTRAND

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

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOW

6. (b) Name of husband or wife JOSEPH CHARTRAND 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased JAN 5, 1870
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>21</u>	<u>8</u>	<u>21</u>	hr. _____ min. _____

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

10. Usual occupation AT HOME

11. Industry or business _____

12. Name JOHN KIERNAN

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

14. Maiden name BRIDGET MURPHY

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

16. (a) Informant Thistle-Brennan

(b) Address 4625 GREER AVE

17. (a) BURIAL (b) Date thereof 9-29-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY

18. (a) Signature of funeral director L. M. Mullen

(b) Address 5165 DELMAR BLVD

19. (a) SEP 26 1941 (b) J. T. Bredack
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County 18

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

(d) Street No. 4625 GREER AVE.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 26
year 1941 hour 5 45 minute 9 A. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Cardiac Decompens 2 hr

Due to Ch. Myocarditis (Heart) 57-

Due to Arteriosclerosis

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

Major findings:
Of operations _____

Of autopsy 930

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? _____

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

23. Signature P. M. Crossman (M. D. or other) MD

Address 4011 Blum Ave Date signed 9/24/41

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.