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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **36116**
Registrar's No. **5220**

FILLED NOV 11 1941

Registration District No. **184**

Primary Registration District No. **200**

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **Carsonville, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
8544 Geiger Road
(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 **Joseph M. Fahey.**

3. (b) If veteran, name war. **No** 3. (c) Social Security No. **None**

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

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

7. Birth date of deceased. **June 29, 1884.**
(Month) (Day) (Year)

8. AGE: Years **57** Months **4** Days **4** If less than one day hr. min.

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

10. Usual occupation. **Accountant**

11. Industry or business. **Termail R.R.**

MOTHER FATHER { 12. Name **Michael Fahey**
13. Birthplace **Ireland**
(City, town, or county) (State or foreign country)
14. Maiden name **Don't know**
15. Birthplace **Ireland**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Leonore Kressley**
(b) Address **8544 Geiger Ave.,**

17. (a) **Burial** (b) Date thereof **Nov. 5/41.**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cem.,**

18. (a) Signature of funeral director **Jos. W. Clark**
(b) Address **1125 Hodiamont Ave.,**

19. (a) **NOV 3 1941** (b) **J. Smith**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **St. Louis**
(c) City or town **Carsonville**
(If outside city or town limits, write "RURAL")
(d) Street No. **8544 Geiger Road**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **2**
year **1941.** hour **7.00** minute **A.M.** M.

21. I hereby certify that I attended the deceased from **Jan 10**
1939 to **Nov 22** - **1941;**
that I last saw h. **im** alive on **Oct. 31** - **1941;**
and that death occurred on the date and hour stated above.

Immediate cause of death
chronic valvular heart disease
Due to **arterio sclerosis**

Due to **none**
Other conditions **none**
(Include pregnancy within 3 months of death)

Major findings:
Of operations **none**
Of autopsy **none**

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 **John W. Clark** (M. D. or other)
Address **1125 Hodiamont Ave** Date signed **11/3-41**

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

Dr. John D. Poe,
1492 Hodiament Ave.,
Mu. 4740.

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. 3225

P. O. Address 1125 Hodiament Ave.,

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.

ADV 17 1947