

FILED NOV 4 1942

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

DR 11... 31943

State File No.

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **8829**

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:
51 LEWIS PLACE
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether
In this community **20 YRS.** (Month) (Year) (Specify whether
years, months or days)

3. (a) PRINT FULL NAME **CATHERINE FLANNAGAN**

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

4. Sex **FEMALE** 5. Color or race **WHITE** 6. (a) Single widowed, married, divorced **2**

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

7. Birth date of deceased **OCTOBER 13 1854**
(Month) (Day) (Year)

8. AGE: Years **88** Months **0** Days **10** If less than one day
.....hr.min.

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

10. Usual occupation **HOUSEWORK**

11. Industry or business **SELF**

12. Name **MURRAY**

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

14. Maiden name **UNKNOWN**

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

16. (a) Informant **August Becker**

(b) Address **51 Lewis Place**

17. (a) **Burial** (b) Date thereof **OCT. 26 1942**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Galway Cem**

18. (a) Signature of funeral director **Wayland Finck Home**

(b) Address **Westfield Illinois**

19. (a) **OCT 24 1942** (b) **J. F. Burdick**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **000**
(c) City or town **ST. LOUIS**
(If outside city or town limits, write "RURAL")
(d) Street No. **51 LEWIS PLACE**
(If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country **0**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **OCT.** day **23RD**
year **1942** hour **6** minute **A** M.

21. I hereby certify that I attended the deceased from **9.30-37**
....., 19....., to **10-23-42**, 19.....;
that I last saw her alive on **10-15-42**, 19.....;
and that death occurred on the date and hour stated above.

Immediate cause of death **general arteriosclerosis**

Due to **chronic induration**

Due to **.....**

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

Major findings:
Of operations.....
Of autopsy.....

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 **.....** (M. D. or other) **MD**
Address **5074 N Union** Date signed **10-24-42**

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

MOTHER FATHER

JAN 13 1949

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..... *John Hetter*

P. O. Address..... 38

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.