S. No. 2
M—5-42
v. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

8266

State File No.

Registration District No. MAR 20 1943 318

Primary Registration District No. 1003

Registrar's No. 2293

1. PLACE OF DEATH:

(a) County

(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:
Barnard Skin & Cancer Hospt. 0
(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: 944

(a) State Illinois (b) County Macoupin

(c) City or town Gillispie 11 N.B.
(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 2

3. (a) PRINT FULL NAME John E. Feehan

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race White

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

6. (b) Name of ~~husband~~ or wife Susie Feehan

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

7. Birth date of deceased 7 (Month) 15 (Day) 1875 (Year)

8. AGE: Years 67 Months 7 Days 23 If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name Pat Feehan
13. Birthplace Ireland 4 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Myrna Flannery
15. Birthplace not known 9 (City, town, or county) (State or foreign country)

16. (a) Informant John E Feehan / Eva Smith
(b) Address Barnard S + C Hospital

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 3-9-43 (Month) (Day) (Year)
(c) Place: burial or cremation Odell, Ill.

18. (a) Signature of funeral director Provost Und. Co.
(b) Address 3710 N. Grand

19. (a) MAR 9 1943 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

844

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 8nth year 1943 hour 8:50 minute P. M.

21. I hereby certify that I attended the deceased from Feb. 22nd 1943 to March 8th 1943 that I last saw him alive on March 8th 1943. and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Surgical Shock	4hrs
Due to Pharyngeal hemorrhage	2hrs.
Due to Carcinoma of Right tonsillar fossa and tongue	1 year

Other conditions (Include pregnancy within 3 months of death)
Primary site base of tongue

Major findings:
Of operations 2-23-43 extensive carcinoma Right Pharynx
Of autopsy none 43

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 D. J. Verdon 0 (M. D. or other)

Address Barnard Cancer Hosp Date signed 3-9-43

(Licensed Embalmer's Statement on Reverse Side)

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 Robert L. Brinkman

Licensed Embalmer No. 3553

P. O. Address 9710 N Gran

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.