

S. No. 2  
OM-2.43  
5-17-39  
X3567

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

19521

State File No. \_\_\_\_\_

FILED JUL 8 1943 318

Registration District No. \_\_\_\_\_ Primary Registration District No. 1003

Registrar's No. 5818

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:  
DePaul Hosp.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 days  
(Specify whether years, months or days)

In this community 60 years  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_

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

(d) Street No. 5271 Alcott Ave.  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME John L. Devaney

3. (b) If veteran, name war None

3. (c) Social Security No. No

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

6. (b) Name of husband or wife Sadie Devaney 6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased Nov. 21, 1869  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>73</u>	<u>7</u>	<u>3</u>	hr. _____ min. _____

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

10. Usual occupation Retired

11. Industry or business Locomotive Engineer

12. Name James Devaney

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

14. Maiden name Anna Calaria

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

16. (a) Informant Mrs. Sophia Devaney

(b) Address 5271 Alcott Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/26/43  
(Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park.

18. (a) Signature of funeral director [Signature]

(b) Address 2117 E. Grand Blvd.

19. (a) JUN 2 (Date received local registration) (b) J. F. [Signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 24  
year 1943 hour 3 minute A M.

21. I hereby certify that I attended the deceased from June 18, 1943 to June 23, 1943  
that I last saw him alive on 6-23-43, 1943; and that death occurred on the date and hour stated above.

Immediate cause of death General arteriosclerosis  
hypertension  
atherosclerosis  
hypertension

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 82a!

Duration 6 days

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 [Signature] (M. D. or other) \_\_\_\_\_  
Address 504 [Address] Date signed 6/24/43

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

MOTHER FATHER

**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 Frank A. Moore

Licensed Embalmer No. 3041

P. O. Address 2117 E. 1st St.

**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.**