

1. PLACE OF DEATH:

(a) County St. Charles  
(b) City or town St. Paul  
(c) Name of hospital or institution: St. Paul, Mo.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 5-Months (Specify whether years, months or days)

3. (a) PRINT FULL NAME Rev. James A. Beggan

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

4. Sex M. 5. Color or race W. 6. (a) Single, widowed, married, divorced S.

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

7. Birth date of deceased Nov. 27th., 1901  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
41 8 17 hr. \_\_\_\_\_ min.

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

10. Usual occupation Catholic Priest

11. Industry or business \_\_\_\_\_

12. Name Philip Beggan

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

14. Maiden name Mary Ann Mooney

15. Birthplace St. Louis Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant Rev. Wm. F. Glynn

(b) Address 3010 Washington Blvd.

17. (a) Burial (b) Date thereof 8-18-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Patrick J. Donnelly

(b) Address 3840 Lindell Blvd.

19. (a) 8/21/43 (b) S. Forstner  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 92  
(c) City or town St. Paul  
(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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 14th.  
year 1943 hour 7 minute 45 p. M.

21. I hereby certify that I attended the deceased from Aug 14 1943 to Aug 14 1943  
that I last saw him alive on Aug 14 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Apoplexy

Due to Hypertension

Due to \_\_\_\_\_  
Other conditions 820  
(Include pregnancy within 3 months of death)

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 Nicholas J. Nouch (M. D. or \_\_\_\_\_)

Address O'Fallon, Mo. Date signed 8/17/43

Duration

3 hrs.

5 yrs.

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

92000

FILED SEP 3 1943

681

JAN 4 1944

**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 *Stanley Marshall*

Licensed Embalmer No. *2868*

P. O. Address. *3840 Lindell*

**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.**