DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 2 - 1943

Registration District No. 318

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 30930

Registrar's No. 8576

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

1. PLACE OF DEATH:

(a) County: ST. LOUIS

(b) City or town: (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: JEWISH HOSPITAL (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 0 (Specify whether years, months or days) In this community:

2. USUAL RESIDENCE OF DECEASED:

(a) State: MO (b) County: 000

(c) City or town: ST. LOUIS (If outside city or town limits, write "RURAL") 19 17 9

(d) Street No.: 4496 MARYLAND AVE (If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country: 0

3. (a) PRINT FULL NAME: MARY J. HOCK

3. (b) If veteran, name war:

3. (c) Social Security No.:

4. Sex: F

5. Color or race: W

6. (a) ~~Single~~, widowed, ~~married~~, ~~divorced~~: WIDOWED

6. (b) Name of husband or wife:

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

7. Birth date of deceased: NOV. (Month) 23 (Day) 1866 (Year)

8. AGE: Years 76 Months 10 Days 4 If less than one day hr. min.

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

10. Usual occupation: AT HOME

11. Industry or business:

FATHER 12. Name: JOHN MONEHAN

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

MOTHER 14. Maiden name: ELLEN RYAN

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

16. (a) Informant: Mrs Albert Duckam

(b) Address: 7240 Northmoor Dr.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: 9 30-43 (Month) (Day) (Year)

(c) Place: burial or ~~cremation~~: CALVARY CEM

18. (a) Signature of funeral director: L. M. Mullen

(b) Address: 5165 Delmar Bl

19. (a) SEP 28 1943 (Date received local registrar) (b) J. F. Bausch (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 27 year 1943 hour 9:50 minute P.M.

21. I hereby certify that I attended the deceased from Sept. 3rd 1943, to Sept. 27 1943; that I last saw her alive on Sept. 27th 1943 and that death occurred on the date and hour stated above.

Immediate cause of death: Myocardial Failure — Duration: 2½ wks

Due to: Coronary Thrombosis

Due to: Arteriosclerosis. Hypertension

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

Major findings: Of operations: —

Of autopsy: None

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: Paul K Webb (M. D. or other) M.D.

Address: 721 Olive St. Date signed: 9-28-43

844

(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 H. G. Harris

Licensed Embalmer No. 3384

P. O. Address St Louis

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.

S. No. 2B
0M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Oct

Registration District No. ____ Primary Registration District No. ____ Registrar's No. 8-5-76

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

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

In this community ____

2. USUAL RESIDENCE OF DECEASED:

(a) State ____ (b) County ____

(c) City or town ____
(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 ____

3. (a) PRINT FULL NAME Mary J. Hoch

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

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

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

7. Birth date of deceased Nov. 25 — 1866
(Month) (Day) (Year)

8. AGE: Years 76 | Months 10 | Days ____ | If less than one day ____ hr. ____ min.

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

10. Usual occupation ____

11. Industry or business ____

FATHER
12. Name ____
13. Birthplace ____ (City, town, or county) ____ (State or foreign country)

MOTHER
14. Maiden name ____
15. Birthplace ____ (City, town, or county) ____ (State or foreign country)

16. (a) Informant ____
(b) Address ____

17. (a) ____ (Burial, cremation, or removal) (b) Date thereof ____ (Month) (Day) (Year)
(c) Place: burial or cremation ____

18. (a) Signature of funeral director ____
(b) Address ____

19. (a) OCT 5 1943 (Date received local registrar) J. F. Bruneck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 27 year 1943 hour ____ minute ____ M.

21. I hereby certify that I attended the deceased from ____, 19____ to ____, 19____; that I last saw h____ alive on ____, 19____; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death ____	
Due to ____	
Due to ____	
Other conditions (Include pregnancy within 3 months of death) ____	

Major findings:
Of operations ____
Of autopsy ____

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 ____ (M. D. or other) ____
Address ____ Date signed ____

SUPPLEMENTARY

30930