

39064

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED DEC 11 1943

Registration District No. _____

Primary Registration District No. 3063

Registrar's No. 2695

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis County Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 17 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town Richmond Heights
(If outside city or town limits, write "RURAL")
(d) Street No. 6300 Clayton Road
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME William Brannan

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 Laura Brannan 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 8-25-1864
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
79 3 7 hr. min.

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

10. Usual occupation None

11. Industry or business --

12. Name Joseph Brannan
13. Birthplace ? Ireland
(City, town, or county) (State or foreign country)
14. Maiden name Margaret O'Brien
15. Birthplace ? Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant W. D. BRANNAN (SON)

(b) Address 6300 CLAYTON RD.

17. (a) BURIAL (b) Date thereof DEC 4 43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY CEM.

18. (a) Signature of funeral director M. V. Grogan

(b) Address 7146 MANCHESTER

19. (a) DEC 11 1943 (b) E. G. Mc Gowan, M.D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day December
year 1943 hour 2:10 minute A. M.

21. I hereby certify that I attended the deceased from 11-15-43, 19____, to 12-2-43, 19____;
that I last saw him alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 1 hour

Due to My partner in year

Due to _____

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

Major findings: Of operations (Signature) 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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature (Signature) (M. D. or other) _____
Address St. Louis County Hospital Date signed 12-2-43

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

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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

Albert G. Hoppe

Licensed Embalmer No.....

29741

P. O. Address.....

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.