V. S. No. 2
00M—2-43
ev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 22 1943

Registration District No. 318

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 40256

Primary Registration District No. 1003

Registrar's No. 10736

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 Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 weeks (Specify whether years, months or days)

In this community Birth

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000 128

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

(d) Street No. 8506 Church Rd.
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Joan Ruth Meagher

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife None

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

7. Birth date of deceased April 25, 1935 (Month) (Day) (Year)

8. AGE: Years 8 Months 7 Days 9 If less than one day ____ hr. ____ min.

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

10. Usual occupation Child

11. Industry or business

FATHER
12. Name Edwin Meagher
13. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name Florence Goetting
15. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country)

16. (a) Informant Mrs Florence Meagher

(b) Address 8506 Chruch Rd.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/7/43 (Month) (Day) (Year)

(c) Place: burial or cremation Friedens Cemetary

18. (a) Signature of funeral director Math Hermann & Son

(b) Address 2161 East Fair Ave

19. (a) DEC 7 1943 (Date received local registrar) J. F. Bodeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 4th year 1943 hour 2:00 PM minute ____ M.

21. I hereby certify that I attended the deceased from 10/4, 1943, to 12/4, 1943 that I last saw h. alive on 12/4, 1943 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Edema	3 days
Due to Septicemia	3 yrs
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 [illegible] (M. D. or other)

Address 146 [illegible] Date signed

(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.....Francis A. Williamson

Licensed Embalmer No.....3565

P. O. Address.....St Louis Mo

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.