V. S. No. 2
100M—2-43
Rev. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 16 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 43726

Registration District No. 317 Primary Registration District No. 6076 Registrar's No. 2751

1. PLACE OF DEATH:
(a) County: St. Louis
(b) City or town: Jefferson Barracks
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Veterans' Administration Facility
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Adm. Oct. 21, 1943 (Specify whether
In this community — years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: St. Louis
(c) City or town: Pine Lawn
(If outside city or town limits, write "RURAL")
(d) Street No.: 4115 Beachwood Ave.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country: 0

3. (a) PRINT FULL NAME: H Y L A N D, Patrick W.
3. (b) If veteran, name war: W.W. #1
3. (c) Social Security No. 487-18-1509
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Single
6. (b) Name of husband or wife: —
6. (c) Age of husband or wife if alive: — years
7. Birth date of deceased: July 26, 1889 (Month) (Day) (Year)
8. AGE: Years 54 Months 4 Days 13 If less than one day hr. min.
9. Birthplace: Sligo, Ireland, (Naturalized) (City, town, or county) (State or foreign country) 4
10. Usual occupation: Laborer
11. Industry or business: —
12. FATHER Name: James Hyland.
13. FATHER Birthplace: Unknown (City, town, or county) Ireland (State or foreign country) 4
14. MOTHER Maiden name: Mary Devenney.
15. MOTHER Birthplace: Unknown (City, town, or county) Ireland (State or foreign country) 4
16. (a) Informant: M. Schulig Cl. Clerk,
(b) Address: Vets. Adm. Fac., Jeff. Brks., Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Dec. 11/43 (Month) (Day) (Year)
(c) Place: burial or cremation: Calvary Cem.,
18. (a) Signature of funeral director: Jos. W. Clark
(b) Address: 1125 Hodiamont Ave.,
19. (a) DEC 13 1943 (Date received local registrar) (b) E. G. McGarran, M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 9th year 1943 hour 12:12 AM. minute M.
21. I hereby certify that I attended the deceased from October 21, 1943 to December 9, 1943 that I last saw him alive on December 9, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
CARCINOMA OF ESOPHAGUS. About 1-yr.
OTHER CONDITIONS: —
CORONARY ARTERIOSCLEROTIC HEART DISEASE, MYOCARDIAL DAMAGE, AND ANGINAL SYNDROME. UNKNOWN
ARTERIOSCLEROSIS, GENERAL. UNKNOWN.
(Include pregnancy within 3 months of death)

Major findings:
Of operations: No operation.
Of autopsy: No autopsy. 46a

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): No
(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? Means of injury:
23. Signature: L. M. COCHRAN, M.D. (M.D. or other)
Address: CHIEF MEDICAL OFFICER. Date signed: 12-9-43

(Licensed Embalmer's Statement on Reverse Side)

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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.....

Licensed Embalmer No. 3225

P. O. Address 1125 Hodiamont Ave.,

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.