

FILED FEB 1 1944

318

Registration District No. 1003

Registrar's No. 6419

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town St. Louis
(c) Name of hospital or institution: St. Johns Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (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 Jennings
(d) Street No. 8715 Acacia (If rural, give location) JNR.
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Martin Bernard Meagher
3. (b) If veteran, name war _____ 3. (c) Social Security No. None

4. Sex M 5. Color or Race W 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: January 13 1944
(Month) (Day) (Year)

8. AGE: Years 0 Months 0 Days 6 If less than one day hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

12. Name John Meagher

13. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Frances Velk

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

16. (a) Informant John Meagher
(b) Address 8715 Acacia

17. (a) Burial (b) Date thereof 1-21-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Stroot-Carroll
(b) Address 4600 Natural Bridge

19. (a) JAN 21 1944 (b) J. F. Bradach
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan. day 19
year 1944 hour 10 minute 45 P. M.

21. I hereby certify that I attended the deceased from Jan 13, 1944, to Jan 19, 1944, that I last saw him alive on Jan 19, 1944, and that death occurred on the date and hour stated above.

Immediate cause of death: Retropneumonal pneumonia & Sanguis of small bowel Duration 6 days

Due to Malformation at birth

Due to _____

Other conditions: 157
(Include pregnancy within 3 months of death)

Major findings: As above

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 [Signature] (M. D. or other) MD
Address 4126 Sherwood Date signed 1/20/44

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

2
43
39
35697

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.....

Sheldon Collier

Licensed Embalmer No.....

3382

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.