

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **1011**

FILED FEB 1 1944 318

Primary Registration District No. **1003**

Registrar's No. **727**

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:
Enroute to City Hospital 3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution None
In this community Life
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County.....
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1721 Hoehn St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME JEREMIAH J. SPILLANE

3. (b) If veteran, name war No
3. (c) Social Security No. 486-14-750B

4. Sex M 5. Color or Race W
6. (a) Single, widowed, married, divorced married

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

7. Birth date of deceased May 26th 1882
(Month) (Day) (Year)

8. AGE: Years 61 Months 7 Days 26
If less than one day hr. min.

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

10. Usual occupation Houseman

11. Industry or business DePaul Hospital

12. Name John Spillane

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

14. Maiden name Margaret Howard

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

16. (a) Informant Barbara Spillane

(b) Address 1721 Hoehn St.

17. (a) Burial (b) Date thereof 1/24/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cem.

18. (a) Signature of funeral director A. W. M. Laughlin

(b) Address 2301 Lafayette Ave.

19. (a) JAN 25 1944 J. F. Bredack
(Date received locally) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 22nd
year 1944 hour 7 minute 30 a. 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.

Immediate cause of death.....

Coronary Occlusion
Coronary Atherosclerosis
Oedema Brain

Due to.....

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

Major findings:
Of operations.....

Of autopsy.....

Duration

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 Thomas J. Callahan (M. D. or other) 1-22-44
Address Deputy Coroner Date signed.....

MOTHER FATHER

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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 L.R. Casper

Licensed Embalmer No. 3633

P. O. Address 2317 Rofay

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.