S. No. 2
M—2-43
5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED MAR 6 1944 318

State File No. 24842

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2014

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: 3947 Ashland Ave. /
(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: 000

(a) State Missouri (b) County 17

(c) City or town St. Louis 91°
(If outside city or town limits, write "RURAL")

(d) Street No. 3947 Ashland Ave.
(If rural, give location)

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

If yes, name country 0

3. (a) PRINT FULL NAME Katherine T. Ahearn

3. (b) If veteran, name war _____

3. (c) Social Security No. None

4. Sex F

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 About 1860
(Month) (Day) (Year)

8. AGE: Years About 84 | Months | Days | If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) Ireland 4 (State or foreign country)

10. Usual occupation At Home

11. Industry or business _____

FATHER
12. Name Denis Ahearn
13. Birthplace _____ (City, town, or county) Ireland 4 (State or foreign country)

MOTHER
14. Maiden name Margaret Casey
15. Birthplace _____ (City, town, or county) Ireland 4 (State or foreign country)

16. (a) Informant Agnes C. Maginnis
(b) Address 3947 Ashland Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/1/44 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary

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

19. (a) FEB 29 1944 (Date received local registrar) (b) J. F. Budeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 27
year 1944 hour 10 minute 50 A M.

21. I hereby certify that I attended the deceased from Jan 15th, 1938, to Feb. 27th, 1944 that I last saw her alive on Feb. 24th, 1944 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cardiac Asthma	6 hours
Due to Chronic myocarditis	2 y.
Due to Arterio-sclerosis.	10 y.
Other conditions (Include pregnancy within 3 months of death) Mitral regurgitation	4 y.

Major findings:
Of operations None made
Of autopsy None made

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 0

23. Signature Joseph Davie (M. D. or other)
Address 343 N. 9th St. Date signed 2-28-44

(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 [signature]

Licensed Embalmer No. 2265

P. O. Address 46 [illegible] Port Bridgeon

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.