

No. 2  
-2-43  
-17-39  
X35697

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

16487

FILED JUN 9 1944

State File No. 4893  
Registrar's No. 8687

Registration District No. 318

Primary Registration District No. 1003

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:  
4145 ST. LOUIS  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution  
In this community...  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County 000  
(c) City or town St Louis 19  
(If outside city or town limits, write "RURAL") 9/10  
(d) Street No. 4145 ST LOUIS AVE  
(If rural, give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME ANN C. KEHOE

3. (b) If veteran, name war 3. (c) Social Security No.

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED  
6. (b) Name of husband or wife JOHN J. KEHOE 6. (c) Age of husband or wife if alive 62 years  
7. Birth date of deceased JAN. 6 1892  
(Month) (Day) (Year)

8. AGE: Years 52 Months 4 Days 21 If less than one day hr. min.

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

10. Usual occupation AT HOME

11. Industry or business

12. Name WILLIAM TRATICAN

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

14. Maiden name KATE TIERNEY

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

16. (a) Informant John Kehoe

(b) Address 4145 St Louis Ave

17. (a) BURIAL (b) Date thereof MAY 29-1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY

18. (a) Signature of funeral director S. Muller

(b) Address 5515 Delmar Bl

19. (a) MAY 25 1944 (b) J. J. Braddock  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 27  
year 1944 hour 5 minute 45 A.M.

21. I hereby certify that I attended the deceased from July 1935, to May 27 1944  
that I last saw her alive on 5-26 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive Cardiovascular Disease

Due to Flaccid Aneurysm

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: 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 Carl H. ... (M. D. or other)

Address Humboldt Bldg Date signed 5-27-44

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

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

**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 *H. G. Larris*.....

Licensed Embalmer No. *3384*.....

P. O. Address *St Louis*.....

**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.**