

State File No.

Registrar's No.

FILED AUG 21 1944  
Registration District No. 317

Primary Registration District No. 6076

1722

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Creve Coeur  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
-----  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Houlihan, John J.

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

4. Sex Mas 5. Color or race Wh 6. (a) Single, widowed, married. 2 divorced Widowed

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

7. Birth date of deceased Dec 6 1860  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

83 8 5 hr. min.

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

10. Usual occupation.....

11. Industry or business Houlihan Nursery Co.

12. Name Patrick Joseph Houlihan

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

14. Maiden name Mary Ann Crinion

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

16. (a) Informant Family

(b) Address Creve Coeur, Mo.

17. (a) Burial (b) Date thereof 8-14-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director M. J. Croghan

(b) Address 7146 Manchester

19. (a) AUG 16 1944 (b) E. D. McDevan, M.D.  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis

(c) City or town Creve Coeur  
(If outside city or town limits, write "RURAL")

(d) Street No. -----  
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 11  
year 1944 hour 9 minute 45 A. M.

21. I hereby certify that I attended the deceased from July 32  
1944 to Aug 9 1944  
that I last saw him alive on Aug 8 and that death occurred on the date and hour stated above.

Immediate cause of death.....  
Chronic Myocarditis Duration 10 yrs

Due to.....

Due to..... 93h

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

Major findings: Of operations Edema shortness breath

Of autopsy None

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) (e) Means of injury.....

While at work?.....

3. Signature D. B. Leavelle (M. D. or other)  
Address 427 Metropol Bldg Date signed 8-12-44

**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..... *Albert G. Hoppe* .....

Licensed Embalmer No..... *2971* .....

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.**