S. No. 2
DM—5-43
v. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 18 1944

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 29594

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7646

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Louis City Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 days (Specify whether
In this community 0
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 5021 Northland

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

(d) Street No. 5021 Northland
(If rural, give location)

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

If yes, name country 0

3. (a) PRINT FULL NAME Hugh McTiernan

3. (b) If veteran, name war

3. (c) Social Security No. 490-22 1975

4. Sex M

5. Color or race N

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Anna McGrath

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

7. Birth date of deceased unknown (Month) (Day) (Year)

8. AGE: Years abt 70 Months Days If less than one day hr. min.

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

10. Usual occupation Retired

11. Industry or business

FATHER
12. Name Hugh McTiernan
13. Birthplace Ireland (City, town, or county) 4 (State or foreign country)

MOTHER
14. Maiden name unknown
15. Birthplace (City, town, or county) 9 (State or foreign country)

16. (a) Informant Jno McTiernan
(b) Address 5504 Hebert

17. (a) Calvary Cem (Burial, cremation, or removal) (b) Date thereof Sept 6 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Thos J Truan
(b) Address 1519 S Grand

19. (a) SEP 5 1944 (Date received local registrar) (b) J Fredeck (Registrar's signature)

844

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 4th hour 11 minute 45 A. M.

21. I hereby certify that I attended the deceased from 8/28/44, 19 , to Sept. 4th, 19 44 that I last saw him alive on Sept. 4th, 19 44 and that death occurred on the date and hour stated above.

Immediate cause of death Peritonitis

Due to Perforated appendix

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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature K. R. J. Hademan (M. D. or other)
Address 1515 Lafayette Date signed 9/5/44

(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.....

Licensed Embalmer No. 3714

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.