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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 10 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32002

State File No. _____

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **9242**

1. PLACE OF DEATH:
(a) County St. Louis Mo.
(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Emma Desloge Hosp.
(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:
(a) State MO (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4106 Cottage (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Ahern, John
3. (b) If veteran, name war No. 3. (c) Social Security No. No.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 10-30-44
year _____ hour 3:50 PM minute _____ M. _____
21. I hereby certify that I attended the deceased from 10-28-44
_____ 19____, to _____ 10-30-44 _____ 19____;
that I last saw him alive on 10-30-44
and that death occurred on the date and hour stated above.

4. Sex M 0 5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
62 years alive _____ years
7. Birth date of deceased: Oct 13 1869
(Month) (Day) (Year)

Immediate cause of death _____ Duration _____
Aspirator Pneumonia-Bilateral 1 day
Due to Carcinoma of Esophagus - ?
Spontaneous perforation into
Due to Trachea 1 day
Other conditions Unk. Generalized Metastasis
(Include pregnancy within 3 months of death)

8. AGE: ~~77~~ Years 75 Months 0 Days 17
If less than one day _____ hr. _____ min.
9. Birthplace Ireland _____ (State or foreign country)
10. Usual occupation Retired Plumber

Major findings: _____ Of operations None. H/O
Of autopsy as above
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business _____
12. Name John Ahern
13. Birthplace Ireland _____ (State or foreign country)
14. Maiden name Johnanna Mahon
15. Birthplace Ireland _____ (State or foreign country)

16. (a) Informant Catharine Ahern
(b) Address 4106 Cottage
17. (a) Buried (b) Date there 11-7-44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation burial
18. (a) Signature of funeral director J. J. Brudek
(b) Address _____
19. (a) OCT 31 1944 (b) J. J. Brudek
(Date received local health) (Registrar's signature)

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 John Sciortino (M. D. or other) _____
Address Emma Desloge Hosp. Date signed 10/31/44

(Licensed Embalmer's Statement on Reverse Side)

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

Robert L. Brinkman

Licensed Embalmer No. *3553*

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.