

FILED NOV 30 1944 318

9801

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

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:  
3820 Laclede Ave.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community 80 Years In St. Louis  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3820 Laclede Ave.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MICHAEL J. O'LOUGHLIN

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Mary O'LOUGHLIN 6. (c) Age of husband or wife if alive 76 years  
7. Birth date of deceased July 12 1856  
(Month) (Day) (Year)

8. AGE: Years 88 Months 4 Days 5 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation RETIRED

11. Industry or business Teamster

12. Name Anthony O'Loughlin

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

14. Maiden name Mary COONEY

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

16. (a) Informant Mary O'LOUGHLIN

(b) Address 3820 Laclede Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 20/44  
(Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cem

18. (a) Signature of funeral director Horowitz & Son

(b) Address 2906 Gravois Ave

19. (a) NOV 19 1944 (b) J. J. Brakes  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV day 17 year 1944 hour 1 20 minutes \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 11-1-44 to 11-17-44 that I last saw him alive on 11-16-44 and that death occurred on the date and hour stated above.

Immediate cause of death Arterio-sclerotic Hypertension Disease Duration 17 days

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions Renal Coma 2 days

Major findings: Of operations \_\_\_\_\_ Of autopsy \_\_\_\_\_

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? \_\_\_\_\_  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature H. J. Randorick (M. D. or other) Address 4290 W Pine Bo Date signed 11-18-44

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

*David Van Fossen*

Licensed Embalmer No.

*4242*

P. O. Address

*2906 Gavois*

**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.**