

FILED DEC 23 1944

Registration District No. _____

Primary Registration District No. **1003**

Registrar's No. **10772**

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:
8671 Oriole Ave.
(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

3. (a) PRINT FULL NAME **Michael Joseph Flaherty.**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **492-03-8552**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married.**

6. (b) Name of husband or wife **Julia Flaherty** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Sept. 20, 1874**
(Month) (Day) (Year)

8. AGE: Years **70** Months **2** Days **26** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Retired. Shoe Worker.**

11. Industry or business **Brown Shoe Co.**

12. Name **Patrick Flaherty**

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

14. Maiden name **MA. EUST. Flaherty.**

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

16. (a) Informant **Julia A. Flaherty**
(b) Address **8671 Oriole Ave.**

17. (a) Burial (b) Date thereof **Dec. 19, 1944**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **James Nielsen**
(b) Address **1131 Union Blvd.**

19. (a) **DEC 18 1944** (Date received local registrar) **J. P. Murphy** (Registrar's signature)

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. **8671 Oriole Ave.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** **15.** day year **1944** hour **8.** minute **30p.** M.

21. I hereby certify that I attended the deceased from **Sept. 26** **1943** to **Dec. 15** **1944** that I last saw him alive on **Dec. 13** **1944** and that death occurred on the date and hour stated above.

Immediate cause of death **acute dilatation of myocardium**
chronic myocarditis
Due to **degenerative myocardial insufficiency**
Due to **secondary anemia**
chronic bronchitis
Other conditions **arteriosclerosis**
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Major findings: Of operations **none**
Of autopsy **none**

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 **U**
23. Signature **J. P. Murphy** (M. D. or other) _____
Address **2616 So. Kings Highway** Date signed **12/16/1944**

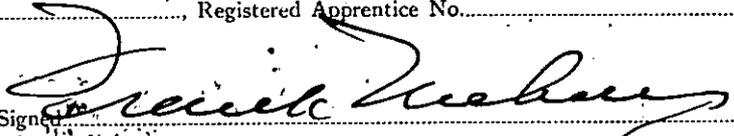
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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. 2915

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.