

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 25 1945
Registration District No. 318

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

State File No. _____
Registrar's No. (463) 468

Primary Registration District No. _____

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

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:
4464 Delor St
(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 Carrie Geoghegan
(b) If veteran, name war No
(c) Social Security No. No

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife John W Geoghegan
6. (c) Age of husband or wife if alive 56 years
7. Birth date of deceased Jan 28 1890
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
54 11 16 hr. _____ min.

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

10. Usual occupation Housework

11. Industry or business at Home

12. Name Henry Tacke

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

14. Maiden name Anna Wieselmann

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

16. (a) Informant John W Geoghegan

(b) Address 4464 Delore St

17. (a) Burial (b) Date thereof 1 18 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director KRIEGSHAUSER

(b) Address 4228 So. Kingshighway

19. (a) Jan 16 1945 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County MO
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4464 Delore St
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 14
year 1945 hour 8.45 PM minute _____ M.

21. I hereby certify that I attended the deceased from Jan 31
1944 to Jan 14 1945
that I last saw her alive on Jan 14 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Cervix
Generalized Peritonitis
Duration 1 year

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) 48

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 0
23. Signature J. A. O'Sullivan (M. D. or other) MD
Address 421 N. Schirmer Date signed 1-15-45

Dr O Sullivan

421 W. SCARLETT

1230 P.M.

PL 1242

- 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 *Edwin D McDermott*

Licensed Embalmer No. *3024*

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.