

FILED APR 23 1945
 Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 3154

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

6
7
9

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:
1946a Montgomery 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..... 51 Yrs 9 Mons 22 Days
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. 1946a Montgomery St
(If rural, give location)
 (e) Citizen of foreign country?..... 0 (Yes or No)
 If yes, name country.....

3. (a) PRINT FULL NAME Frank Eagan

3. (b) If veteran, name war..... 3. (c) Social Security No. 493-01-4603

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife..... Lillian Eagan 6. (c) Age of husband or wife if alive 52 years
 7. Birth date of deceased..... 6 16 1893
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>51</u>	<u>9</u>	<u>22</u>	hr. _____ min.

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

10. Usual occupation..... Clerk

11. Industry or business.....

MOTHER FATHER { 12. Name Unknown
 13. Birthplace..... Unknown Unknown 9
(City, town, or county) (State or foreign country)
 14. Maiden name Unknown
 15. Birthplace..... Unknown Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Lillian Eagan
 (b) Address 1946a Montgomery St

17. (a) Burial (b) Date thereof 4 -11-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation..... Friedens Cemetery

18. (a) Signature of funeral director..... J. F. Bredak

(b) Address 2228 St. Louis Ave

19. (a) APP 9 (b) J. F. Bredak
(Date received local health officer's report) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 8
 year 1945 hour 2 minute 45 a.m.

21. I hereby certify that I attended the deceased from 12-11-44 19 to 4-6-45 19;
 that I last saw him alive on 4-6-45 19;
 and that death occurred on the date and hour stated above.

Immediate cause of death..... Acute Endocarditis
degenerative Myocarditis
 Due to.....
 Due to.....
 Other conditions.....
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Major findings:
 Of operations.....
 Of autopsy.....

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 J. F. Bredak (M. D. or other).....
 Address 1901 Madison Date signed 4-9-45

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 Marie A. Carlson
Licensed Embalmer No. 3949
P.O. Address St. Louis Mo

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.