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rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED MAY 12 1945

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **3889**

1. PLACE OF DEATH:

(a) County **St. Louis**

(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
4704 San Francisco Ave.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....
(Specify whether years, months or days)

In this community.....
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **088**

(c) City or town **St. Louis** **17**
(If outside city or town limits, write "RURAL"?)

(d) Street No. **4704 San Francisco Ave.** **7**
(If rural, give location)

(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **Johanna Leahy**

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

4. Sex **Female** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **William Leahy** 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased **December 11 1863**
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **30**
year **1945** hour **10** minute **15 P** M.

21. I hereby certify that I attended the deceased from **Jan 33** to **Apr 30** 19**45**
that I last saw **her** alive on **Apr 28** 19**45**
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
81	4	19	hr. min.

Immediate cause of death **Deformities of age.** **4 mo.**

Due to.....

Due to.....

Other conditions **none**
(Include pregnancy within 3 months of death)

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

10. Usual occupation **Housewife**

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings:
Of operations.....

Of autopsy.....

11. Industry or business.....

12. Name **Nick Murphy**

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

14. Maiden name **Mary Murphy**

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

16. (a) Informant **Mazie Vorhauer**
(b) Address **4704 San Francisco Ave.**

17. (a) **Burial** (b) Date thereof **5/3/45**
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director **Stroot-Carroll**
(b) Address **4600 Natural Bridge Ave.**

19. (a) **MAY 1 1945** **J. F. Brudeck**
(Date received local registrar) (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?

While at work.....
(Specify type of place) (c) Means of injury

23. Signature **W. N. Anderson** (M. D. or other) **M.D.**
Address **412 6th Street** Date signed **5/1/45**

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

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17
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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.....

H. J. Jarvis

Licensed Embalmer No.....

3384

P. O. Address.....

St. Louis

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.