V. S. No. 2
00M—2-43
ev. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 9 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 15194

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4863

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:
Missouri Baptist Hospital
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis 6
(If outside city or town limits, write "RURAL")

(d) Street No. 5221 Maffitt Ave.
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Bert Hennessy

3. (b) If veteran, name war

3. (c) Social Security No. 497-03-0388

4. Sex Male

5. Color or race W.

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Emma Hennessy

6. (c) Age of husband or wife if alive years

7. Birth date of deceased 12-3-1877 (Month) (Day) (Year)

8. AGE: Years 67 Months 5 Days 27 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business Burns Detective Agcy.

FATHER
12. Name Michael Hennessy
13. Birthplace Ireland (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Kate
15. Birthplace St. Louis MO (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Emma Hennessy
(b) Address 5221 Maffitt Ave.,

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-2-45 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director SULLIVAN BROTHERS
(b) Address 2849 North Euclid Ave.,

19. (a) JUN 1 1945 (Date received local registrar) J. F. Brodeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 30
year 1945 hour 6 minute 55 P M.

21. I hereby certify that I attended the deceased from May 12, 1945 to May 30, 1945
that I last saw him alive on May 30, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Uremia and peritonitis.

Due to Acute appendiceal abscess followed

Due to by operation

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations Retrocoecal appendicitis with abscess (colon B causative agent
~~Of autopsy~~

Duration

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

23. Signature C H Kilker (M. D. or other)
Address 312 N Grand Date signed 5/31/45

(Licensed Embalmer's Statement on Reverse Side)

Dr. Kilker,
3121 North Grand
Fr. 1244

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 Robert L. Dickson

Licensed Embalmer No. 3653

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.