

U. S. No. 2  
DOM-5-43  
ev. 5-17-39  
P-1 X36671

FILED JUN 4 1945  
Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 4570

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:  
Barnes Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 44 days  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Morgan

(c) City or town Murrayville  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) Citizen of foreign country? 2 (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME JAMES CORNELIUS LONERGAN

3. (b) If veteran, name war Nil

3. (c) Social Security No. Nil

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Francis Lonergan

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

7. Birth date of deceased August 6 1892  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

52 08 9 15 hr. min.

9. Birthplace Morgan County Illinois  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

12. Name John Lonergan

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

14. Maiden name Mary Larley

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

16. (a) Informant Frank Lonergan

(b) Address Murrayville, Ill.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 5-23-45  
(Month) (Day) (Year)

(c) Place: burial or cremation Murrayville, Illinois

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) MAY 23 1945 (Date received local registrar) (b) J. P. Brueck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 21  
year 1945 hour 3 minute 15 A. M.

21. I hereby certify that I attended the deceased from APR. 8, 1945 to MAY 21, 1945  
that I last saw him alive on May 21, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Uremia and hemolytic transfusion reaction

Due to Granuloma thigh, knee, foot

Due to Unknown etiology

Other conditions (Include pregnancy within 3 months of death) 56

Major findings: Of operations \_\_\_\_\_

Of autopsy Large, soft kidney + blood microscopic wat. completed

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 JR Bradley (M. D. or other)  
Address Barnes Hospital Date signed 5/24/45

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

*John G. Anoski*

Licensed Embalmer No.....

*3398*

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.**