S. No. 2
0M—5-43
v. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 25924

FILED SEP 14 1945

Registration District No. 918 Primary Registration District No. 1002 Registrar's No. 7755

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: Alexian Brothers Hospital
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County St. Clair 999

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

(d) Street No. 449 Columbia Rd. NK
(If rural, give location)

(e) Citizen of foreign country? (Yes or No) 2

If yes, name country

3. (a) PRINT FULL NAME William Mannion

3. (b) If veteran, name war Nil

3. (c) Social Security No. None

4. Sex Male 0

5. Color or race White

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

6. (b) Name of husband or wife Annie Mannion

6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased October (Month) 11 (Day) 1878 (Year)

8. AGE: Years 66 Months 10 Days 22 If less than one day hr. min.

9. Birthplace Unknown (City, town, or county) Ireland 4 (State or foreign country)

10. Usual occupation Fireman

11. Industry or business East St. Louis, Fire Dept

MOTHER FATHER

12. Name Henry Mannion

13. Birthplace Unknown (City, town, or county) Ireland 4 (State or foreign country)

14. Maiden name Cecelia Fitzmaurice

15. Birthplace Unknown (City, town, or county) Ireland 4 (State or foreign country)

16. (a) Informant Mrs. Annie Mannion

(b) Address East St. Louis, Ill.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 9-6-45 (Month) (Day) (Year)

(c) Place: burial or cremation East St. Louis, Ill.

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

(b) Address 4700 Washington Blvd.

19. (a) SEP 4 1945 (Date received local registrar) (b) J. F. Budick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 3 year 1945 hour 4:00 minute A. M.

21. I hereby certify that I attended the deceased from July 28 1945 to Sept 1 1945 that I last saw him alive on Sept 1 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac failure, Cerebral Myocardit. Chronic

Due to 5/15

Due to

Other conditions (Include pregnancy within Carcinoma of Prostate

Major findings: Of operation Carcinoma of Prostate

Of autopsy Aug 9-45 Above

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 Milo Mass (M. D. or other) M.D.

Address 429 Main Bldg Date signed 9-14-45

(Licensed Embalmer's Statement on Reverse Side)

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

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 Elmer R. Caldwell

Licensed Embalmer No. 4077

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.