. S. No. 2
0M—5-43
v. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

#29489

FILED NOV 10 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31939

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9485

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution St. Louis City Hospital-Max C. Starkloff (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 11 days (Specify whether In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town (If outside city or town limits, write "RURAL") 4705 Labadie Ave.

Street No. (If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Mary Hannigan

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife

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

7. Birth date of deceased March (Month) 15 (Day) 1871 (Year)

8. AGE: Years 74 Months ~~6~~ 7 Days 16 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Tom Hannigan
13. Birthplace Ireland (City, town, or county) 4 (State or foreign country)

MOTHER
14. Maiden name Bridget Cosgrove
15. Birthplace Ireland (City, town, or county) 4 (State or foreign country)

16. (a) Informant Mrs. Irene Bullock
(b) Address 4705 Labadie Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof II- 5- 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Sullivan Funeral Dir.
(b) Address 2849 No. Euclid Ave.

19. (a) NOV 2 1945 (Date received local registrar) J. F. Bredick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV. day 1st year 1945 hour 1;15 minute P M.

21. I hereby certify that I attended the deceased from 10/21/45, 19, to 11/1/45, 19; that I last saw her alive on 11/1/45, 19; and that death occurred on the date and hour stated above.

Immediate cause of death arteriosclerotic Heart Disease

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

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 Herbert C. Fritz (M. D. or other)

Address 1515 Lafayette 11/1/45 Date signed

(Licensed Embalmer's Statement on Reverse Side)

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. Bunkman

Licensed Embalmer No. 3553

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.