V. S. No. 2
00M—5-43
Rev. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED OCT 25 1945

State File No. 32158

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8938

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: St. John's 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 mo (b) County

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

(d) Street No. 6433 Nashville (If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME John Mahoney

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W June

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

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased June 12, 1874 (Month) (Day) (Year)

8. AGE: Years 71 Months ~~3~~ Days ~~29~~ If less than one day hr. min.

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

10. Usual occupation

11. Industry or business St. Public Service Company

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

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

16. (a) Informant Mildred Mahoney

(b) Address 6433 Nashville

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 10/18/45 (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director M. J. Brogan

(b) Address 7146 manchester

19. (a) OCT 16 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 15 year 45 hour 2 minute 00 A.M.

21. I hereby certify that I attended the deceased from Jan 1945, to 10-15, 1945; that I last saw him alive on 10-14-45, 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cardio vascular Disease	?
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations

Of autopsy

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 [signature] (M. D. [illegible])

Address 607 N Grand Date 10-16-45

(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.....

Licensed Embalmer No. 3575

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.