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

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

#43021

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. 32199

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8964

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Missouri
(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 Memorial
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1mo-5 days (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. 5539 Pershing Ave.
(If rural, give location)

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

If yes, name country

000 17 12 9 0

3. (a) PRINT FULL NAME HARRY MONAGHAN

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Dec 24th. 1864 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
80	9	22	hr. min.

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

10. Usual occupation Steamboat Capt

11. Industry or business Retired

FATHER
12. Name Michael N Monaghan
13. Birthplace (City, town, or county) Ireland (State or foreign country) 4

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

16. (a) Informant May M Cunningham
(b) Address 5539 Pershing Ave.

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

18. (a) Signature of funeral director Harrigan & Sheahan Und Co
(b) Address 4415 Washington Blvd.

19. (a) OCT 17 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 16th
year 1945 hour 8:45 minute A. M.

21. I hereby certify that I attended the deceased from 9/6/45, 19, to 10/16/45, 19;
that I last saw him alive on 10/16/45, 19;
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia

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.

107

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. or other)

Address 1515 Lafayette 10/16/45 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 John Cyonoski

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.