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DEPARTMENT OF COMMERCE
BUREAU OF PUBLIC HEALTH
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35356**

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **9256**

1. PLACE OF DEATH:
(a) County **St. Louis**
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
4620 Margaretta Ave.
(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 **Missouri** (b) County **St. Louis**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **4620 Margaretta Ave.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Frank T. Hanlon**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____
4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced, widowed
6. (b) Name of husband or wife **Mary Hanlon** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **January 1 1878**
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Nov.** day **9** year **1945** hour **8** minute **40** A. M.
21. I hereby certify that I attended the deceased from **Oct 30** to **Nov 9**, 1945.
that I last saw him alive on **Nov 6**, 1945, and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
67 10 8 hr. min.

Immediate cause of death
myocardial failure today
Ca. chexia prob 6 mo
Ca prostate and metastatic ca lungs
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

9. Birthplace **St. Louis Missouri**
(City, town, or county) (State or foreign country)
10. Usual occupation **Messenger**
11. Industry or business **Railway Express**

Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN
Underline the cause to which death should be charged statistically.

MOTHER FATHER
12. Name **Patrick Hanlon**
13. Birthplace **Ireland**
(City, town, or county) (State or foreign country)
14. Maiden name **Mary Egan**
15. Birthplace **Ireland**
(City, town, or county) (State or foreign country)
16. (a) Informant **Gertrude Braun**
(b) Address **4620 Margaretta Ave.**
17. (a) **Burial** (b) Date thereof **11/12/45**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Calvary**
18. (a) Signature of funeral director **Stroot-Carroll**
(b) Address **4600 Natural Bridge Ave.**
19. (a) **NOV 10 1945** (b) **J. F. Braddock**
(Date received local registrar) (Registrar's signature)

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 **W. O. ...** (M. D. or other) _____
Address **2322 N. ...** Date signed **11-10-45**

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.....

Ben C. Hoffman

Licensed Embalmer No.....

4366

P. O. Address.....

St. Louis, Mo

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.