

P. S. No. 2
DOM-5-43
Rev. 5-17-39
I X38671

FILED NOV 29 1945
318

1003

Registrar's No. **9959**

Registration District No. **318** Primary Registration District No. **1003**

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:
St. Ann's Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **13 Years**
In this community **60 Years**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **Margaret Jaas**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____
4. Sex **F. /** 5. Color or race **W.** 6. (a) Single, widowed, married, divorced **W. 2**
6. (b) Name of husband or wife **Emile Jaas** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **March 15th., 1873**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	72	8	0	hr. _____ min.

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

10. Usual occupation **Nil**

11. Industry or business _____

12. Name **Daniel Burnes**
13. Birthplace **Ireland 4**
(City, town, or county) (State or foreign country)
14. Maiden name **Elizabeth Mulligan**
15. Birthplace **Ireland 4**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. James Callahan**
(b) Address **7032 Kingsbury Blvd.**

17. (a) Burial **Calvary Cemetery** (b) Date thereof **Nov 19**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **W. J. Brade**
(b) Address **3840 Lindell Blvd.**

19. (a) **NOV 17 1945** (Date filed and local registrar's signature) (b) **W. J. Brade** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County **St. Louis**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **5301 Page Blvd.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Nov.** day **15th.,**
year **1945** hour **11** minute **a.** M.
21. I hereby certify that I attended the deceased from **Nov 15**, 19 **45** to **Nov. 15**, 19 **45**
that I last saw him alive on **Nov. 15**, 19 **45**
and that death occurred on the date and hour stated above.

Immediate cause of death **Chr. Myocarditis**
Due to **Arterio-sclerosis**
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: **None**
Of operations _____
Of autopsy **None**

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)
(c) Means of injury _____
23. Signature **Wm. J. Langan Jr.** (M. D. or other)
Address **5803 Clyburn St.** Date signed **Nov. 15/45**

Duration **6 hrs**
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

MOTHER, FATHER

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 W H Van Matre

Licensed Embalmer No. 2825

P. O. Address. 4340 Lafayette

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.