V. S. No. 2
100M—5-43
Rev. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

FILED NOV 29 1945

State File No. 35821

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9895

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

**1. PLACE OF DEATH:**

(a) County St Louis
(b) City or town (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution City 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 St Louis
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. 4205 Lexington (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3. (a) PRINT FULL NAME** Michael H. Scanlan

3. (b) If veteran, name war Spanish American
3. (c) Social Security No.

4. Sex Male
5. Color or race Wh
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 October (Month) 27 (Day) 1867 (Year)

**8. AGE:** Years 78 Months 0 Days 17 If less than one day hr. min.

9. Birthplace County Clare (City, town or county) Ireland (State or foreign country)
10. Usual occupation Shoeworker
11. Industry or business
FATHER 12. Name Michael Scanlan
13. Birthplace (City, town, or county) Ireland (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant Mrs. Marie Matouschek
(b) Address 6229 S. Kingshighway
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-16-45 (Month) (Day) (Year)
(c) Place: burial or cremation National Cem
18. (a) Signature of funeral director Chas. F. Stuart
(b) Address 1225 Union Blvd.
19. (a) (Date received local registrar) NOV 15 1945 J. F. Bredeck (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Nov. day 14 year 1945 hour 5 minute 10 A. M.

21. I hereby certify that I attended the deceased from ..., 19..., to ..., 19...; that I last saw h... alive on ..., 19...; and that death occurred on the date and hour stated above.

Immediate cause of death Fracture Skull (rt. Parietal) Cerebral Hemorrhage (Left Frontal) Duration
Suffered when deceased fell in the
Due to Bathroom at his home 4205 Lexington Ave. On Nov. 14 1945 exact time
Due to Unknown
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) Accident
(b) Date of occurrence Nov. 14, 1945
(c) Where did injury occur? St Louis (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home (Specify type of place)
While at work? (e) Means of injury to above

23. Signature Patrick E. Singer (M. D. or other)
Address Day Date signed 2/15

(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 Agowski

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.**