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

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 28 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 39294

Registration District No. 318 | Primary Registration District No. 1003 | Registrar's No. 10988

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:
5937 Julian 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 Mo. (b) County
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 5937 Julian Ave.,
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME CATHERINE HORAN.

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife William F. Horan

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

7. Birth date of deceased April 23, 1858. (Month) (Day) (Year)

8. AGE: Years 87 | Months 7 | Days 23 | If less than one day hr. min.

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

10. Usual occupation Retired

11. Industry or business

FATHER
12. Name James Glancy
13. Birthplace Ireland
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Marcellia Flynn
15. Birthplace Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant Miss. Nelle Horan
(b) Address 5937 Julian Ave.,

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Dec. 17/45. (Month) (Day) (Year)
(c) Place: burial or cremation Moberly, Mo.

18. (a) Signature of funeral director Jos. W. Clark
(b) Address 1125 Hodiamont Ave.,

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 16 year 1945 hour 2.40 minute A.M. M.

21. I hereby certify that I attended the deceased from Dec 1, 1945 to Dec. 16, 1945 that I last saw her alive on Dec 15, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral arteriosclerosis	1 yr.
Due to senility	
Due to —	
Other conditions (Include pregnancy within 3 months of death) —	

Major findings:
Of operations None
Of autopsy None

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?
While at work? (Specify type of place) (e) Means of injury —

23. Signature Dr. Wm J. Langan Jr. (M. D. or other)
Address 5803 Plymouth Ave. Date signed Dec 17/45

(Licensed Embalmer's Statement on Reverse Side)

Dr. W.J.Langan,
5803 Plymouth Ave.,
CA. 0220.

12-1-0117

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 Alfred F. Boedeker

Licensed Embalmer No. 2663

P. O. Address 1125 Hodiamont Ave,

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.