

S. No. 2
M-5-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 14 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6246**
Registrar's No. **2279**

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

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

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:
1026 Frey Avenue
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether
In this community..... (Specify whether
years, months or days)

3. (a) **PRIN Malachy Bernard Fahey**
FULL NAME
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. 31, 1886**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
60 **2** **2** hr. min.

9. Birthplace **St. Louis Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **none**

11. Industry or business

MOTHER FATHER { 12. Name **John Fahey**
13. Birthplace **Ireland** 4
(City, town, or county) (State or foreign country)
14. Maiden name **Mary Cogan**
15. Birthplace **Ireland** 4
(City, town, or county) (State or foreign country)

16. (a) Informant **Mary Rose Fahey**
(b) Address **1026 Frey**

17. (a) **burial** (b) Date thereof **3-6-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**
Thos. J. Finan & Sons

18. (a) Signature of funeral director
(b) Address **1519 S. Grand Blvd**

19. (a) **W. J. B. [Signature]** (b) **J. F. Budeck**
(Date of death) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **oac**
(c) City or town **St. Louis** (If outside city or town limits, write "RURAL") **1317**
(d) Street No. **City Sanitarium** (If rural, give location) **7**
(e) Citizen of foreign country?..... (Yes or No) **0**
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **3** year **1947** hour **5** minute **30 P** M.
21. I hereby certify that I attended the deceased from **March 2** 19**47**, to **March 3** 19**47**
that I last saw him alive on **March 3** 19**47**
and that death occurred on the date and hour stated above.

Immediate cause of death **Acute Corning Thrombosis** Duration
Due to.....
Due to.....

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).....
(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)
Means of injury **H. J. Moore**
23. Signature **H. J. Moore** (M. D. or other) **0**
Address **917-5018** Date signed **3-4-47**

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 Ketter

..... Licensed Embalmer No. 3880.....

..... 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.