

No. 2
-12-45
-17-39
X47070

FILED APR 25 1947
318

State File No. 3957
Registrar's No.

Registration District No. Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County St. Louis Mo.

(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 Three

3. (a) PRINT FULL NAME Thos. F. Maher

3. (b) If veteran, name war 1

3. (c) Social Security No. 493-07-0389

4. Sex male

5. Color or race white

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

6. (b) Name of husband or wife Margaret Maher

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

7. Birth date of deceased June 1, 1894
(Month) (Day) (Year)

8. AGE: Years Months Days .If less than one day

52 10 13 hr. min.

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

10. Usual occupation Salesman

11. Industry or business _____

MOTHER FATHER {

12. Name Lawrence Maher 4

13. Birthplace Ireland
(City, town, or county) (State or foreign country)

14. Maiden name Catherine Farrell

15. Birthplace St. Louis, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Margaret Maher

(b) Address 333 Tower Grove Dr. Norman

17. (a) Burial (b) Date thereof 4/17/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Sullivan Bros.

(b) Address 2849 No. Euclid

19. (a) APR 16 1947 (b) J. F. Brebeck
(Date of registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 000

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 333 Tower Grove Drive
Normandy, Mo. (Give location)

(e) Citizen of foreign country? _____ (Yes or No) 9

If yes, name country _____ 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 14
year 1947 hour 9 minutes 30 M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to ruptured Aneurysm of Abdominal Aorta

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? _____

23. Signature of physician Samuel E. J. [unclear] (M. D. or other) _____
Address _____ Date signed 4/14/47

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

MAY 1 1947

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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 Robert L. Burkina
Licensed Embalmer No. 3553

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.