No. 2
-1/47
-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED AUG 16 1947

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 29906

Registration District No. [illegible]

Primary Registration District No. 6076

Registrar's No. 1657

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Koch Hos. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Robert Koch Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 Yr 3 Days (Specify whether years, months or days)

In this community Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 000

(c) City or town St Louis 17 (If outside city or town limits, write "RURAL")

(d) Street No. 2435 Carr 9 (If rural, give location) 1

(e) Citizen of foreign country? — (Yes or No)

If yes, name country —

3. (a) PRINT FULL NAME John Joseph HANCEY

3. (b) If veteran, name war —

3. (c) Social Security No. 497-07-3963

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife —

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

7. Birth date of deceased 3 (Month) 2 (Day) 07 (Year)

8. AGE: Years 40 Months 5 Days 3 If less than one day ... hr. ... min.

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

10. Usual occupation Property Gen - St Louis Brokers

11. Industry or business

MOTHER / FATHER

12. Name Patrick Hanley

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

14. Maiden name Mary Callahan

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

16. (a) Informant Hospital Records

(b) Address Koch Hospital

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-8-47 (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Arthur J. Donnelly

(b) Address 3840 Lindell Blvd

19. (a) 8-7-47 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 5 year 1947 hour 6 minute 40 A.M.

21. I hereby certify that I attended the deceased from 3-14-, 1947 to 8-5-, 1947; that I last saw h[illegible] alive on 8-4, 1947; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pulmonary Tuberculosis	2
	1 year
Due to:	
Due to: 138	
Other conditions: Diabetes mellitus (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN

Underline the cause of 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? (Specify type of place)

(e) Means of injury

While at work?

23. Signature Dr John T. Craig M.D. (M. D. or other)

Address Robert Koch Hospital Date signed 8-5-47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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

JUN 22 1954

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 Stanley Marshall

Licensed Embalmer No. 2868

P. O. Address 3840 Lindell

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.