FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED OCT 24 1947

Registration District No. 318

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 36023

Primary Registration District No. 1003

Registrar's No. 9310

WRITE PLAINLY—USING 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: 3225 No. Florissant Ave. (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 Years 5 Months (Specify whether years, months or days)
In this community

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. 3225 No. Florissant Ave. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME John McGovern
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M.
5. Color or race W
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife Emma Getz
6. (c) Age of husband or wife if alive years
7. Birth date of deceased January (Month) 8 (Day) 1858 (Year)

8. AGE: Years 89 Months 8 Days 29 If less than one day hr. min.

9. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Laborer
11. Industry or business

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

MOTHER
14. Maiden name Anne Dont Know
15. Birthplace Ireland (City, town, or county) (State or foreign country)

16. (a) Informant Little Sisters of Poor
(b) Address 3225 No. Florissant Ave.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-8-47 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery
18. (a) Signature of funeral director Arthur J. Donnelly
(b) Address 3840 Lindell Blvd
19. (a) OCT 8 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 7th year 1947 hour 2 minute A. M.
21. I hereby certify that I attended the deceased from June 12, 1947, to Oct 7, 1947, that I last saw him alive on Oct 4, 1947, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Chronic Myocarditis	???
Senility	???
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death): None	
Major findings: Of operations: None	
Of autopsy: None	

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) None
(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)
While at work? (e) Means of injury
23. Signature Bernard L. Holtz (M. D. or other)
Address 2302 Salisbury St. Date signed 10-7-47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

MAR 6 1959

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 Lundeen

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 11 01

Registration District No. 314 Primary Registration District No. 1003 Registrar's No. 9312

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:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

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

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME John McGovern

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife Emma

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

7. Birth date of deceased Jan 8 1848
(Month) (Day) (Year)

8. AGE: Years 89 Months 8 Days 28 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

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

14. Maiden name

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) J. F. Broderick (Registrar's signature) NOV 3 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Day
year 1947 hour minute 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 — 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? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

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

S-36023