

FILED DEC 31 1947
Registration District No. **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County..... **St. Louis**

(b) City or town..... **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **1014 Park Ave. /**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... **27 years.** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... **Missouri** (b) County..... **000**

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

(d) Street No. **1014** **Park Ave.**
23 (If rural, give location)

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

If yes, name country.....

3. (a) PRINT FULL NAME **John Joseph Cleary**

3. (b) If veteran, **none** name war.....

3. (c) Social Security No. **none-**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **December** day **13th.**
year..... **1947.** hour..... minutes **20** M.

4. Sex..... **male** 5. Color or race..... **white**

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

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

7. Birth date of deceased..... **January, 17th, 1883**
(Month) (Day) (Year)

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. Duration

8. AGE:

| Years | Months | Days | If less than one day |
|-----------|-----------|-----------|----------------------|
| 64 | 10 | 26 | hr. min. |

Immediate cause of death..... **Coronary Occlusion**

Due to..... **Coronary Sclerosis**

Due to..... **g/f**

Other conditions..... (Include pregnancy within 3 months of death)

9. Birthplace..... **St. Charles Mo. 6**
(City, town, or county) (State or foreign country)

10. Usual occupation..... **Fish Merchant**

PHYSICIAN

Major findings:
Of operations.....
Of autopsy.....

Underline the cause of which death should be charged statistically.

11. Industry or business.....

12. Name..... **John Cleary**

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

14. Maiden name..... **Mary Neylon**

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

16. (a) Informant..... **John J. Cleary**

(b) Address..... **1113a St. Louis Ave.**

17. (a) **Burial** (b) Date thereof..... **12-16-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation..... **Calvary Cemetery**

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)

18. (a) Signature of funeral director..... **Hy. Leidner U. Co.**

(b) Address..... **2223 St. Louis Ave.**

19. (a) **DEC 15 1947** (b) **J. F. Bredek**
(Date received local registrar) (Registrar's signature)

23. Signature..... **John J. Cleary** (M or other) **3**

Address..... **Neylon** Date signed..... **12/15/47**

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 P. Buchholz

Licensed Embalmer No. 1674

P. O. Address 2223 St. Louis 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.