FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED JUL 23 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 24526 6439

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

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: 5861 Cates Ave.
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis

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

(d) Street No. 6425 Spencer Pl.,
(If rural, give location)

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

3. (a) PRINT FULL NAME ROse Meehan

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Daniel Meehan

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

7. Birth date of deceased June 4, 1876
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
✓	72	1	13	hr. min.

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

10. Usual occupation Retired

11. Industry or business ? Gillespie

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

MOTHER
14. Maiden name Don't Know
15. Birthplace (City, town, or county) Ireland (State or foreign country)

16. (a) Informant Joseph Meehan
(b) Address 6425 Spencer Pl.,

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 21/48 (Month) (Day) (Year)
(c) Place: burial or cremation National Cemetery

18. (a) Signature of funeral director Jos. W. Clark
(b) Address 1125 Hodiamont Ave.,

19. (a) JUL 21 1948 (Date received local registrar) (b) J. F. Breech (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 17
year 1948 hour 3.30 minute P.M. M.

21. I hereby certify that I attended the deceased from July 7, 1948 to July 17, 1948
that I last saw her alive on July 17, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia — Duration 2 days

Due to

Due to Cardio — Vas — Renal Disease — 16 Mo

Other conditions
(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)
While at work? (e) Means of injury

23. Signature Lew Kinney (M. D. or other) MD
Address 8105 Page Blvd Date signed 7-19-48

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

Dr. Leo Reilly
8105 A Page Blvd.,
Wi. 1021.

6249

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 Albert G. Kaspar

Licensed Embalmer No. 2971

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.