

43  
7-39  
K36671

FILED DEC 8 1948

318

Registration District No. \_\_\_\_\_ Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County St. Louis Mo.

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

(c) Name of hospital or institution St. Paul Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 weeks  
(Specify whether \_\_\_\_\_)

In this community 52 years  
(years, months or days)

3. (a) PRINT FULL NAME Very Reverend Monsignor John W. Marren

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex male 5. Color or race white

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

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased Dec. 10, 1895  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>52</u>	<u>11</u>	<u>13</u>	hr. _____ min. _____

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

10. Usual occupation Clergy

11. Industry or business Blessed Sacrament

12. Name John Marren

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

14. Maiden name Mariorah Keenan

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

16. (a) Informant Mrs. J. Harris

(b) Address 4614 Shenandoah

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 27 48  
(Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Joy A. Howard

(b) Address 119 1st Grand

19. (a) NOV 26 1948 (Date received local registrar) (b) J. B. Jasen (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

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

(d) Street No. 6 5013 (If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 23 year 1948 hour 8 minute 40 P. M.

21. I hereby certify that I attended the deceased from Sept. 47 to Nov-23 1948  
that I last saw him alive on 11-23 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of Colon

Due to metastases

Other conditions Terminal Pneumonia  
(Include pregnancy within 3 months of death)

Duration 1 1/2 yr

Major findings: As above

Of operations \_\_\_\_\_

Of autopsy Not Done

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of Injury \_\_\_\_\_

23. Signature J. W. [unclear] (M. D. or other) \_\_\_\_\_

Address 4952 [unclear] Date signed 11/26/48

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

MOTHER FATHER

**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 *Joseph A. Howard*  
Licensed Embalmer No. *4139*

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.**