

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

17140

State File No. _____

4203

FILED MAY 20 1949

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

Registrar's No. _____

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis Mo.		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		?	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4241 Red Bud, Av.				d. STREET ADDRESS (If rural, give location) 4241 Red Bud Av.			
3. NAME OF DECEASED (Type or Print) a. (First) Michael J. b. (Middle) _____ c. (Last) Callahan			4. DATE OF DEATH (Month) (Day) (Year) 5 10 49				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 12-10-1879	9. AGE (In years last birthday) 69	IF UNDER 1 YEAR Months 5 Days 0	IF UNDER 24 HRS. Hours 0 Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Police Captain		11. BIRTHPLACE (State or foreign country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME M. J. Callahan			13b. MOTHER'S MAIDEN NAME Ellen Brosnahan			14. NAME OF HUSBAND OR WIFE Agnes Callahan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. A. B. Callahan, 4241 Red Bud			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage			INTERVAL BETWEEN ONSET AND DEATH 2 days
				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension & Cerebral Hemorrhage, 5 yrs.			
				DUE TO (c) _____			
				II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 83			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 331X			
22. I hereby certify that I attended the deceased from April 3, 1949 to May 10, 1949 , that I last saw the deceased alive on May 9, 1949 , and that death occurred at 4:30 p.m. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Ueli				23b. ADDRESS 2202 University St.		23c. DATE SIGNED 5/10/49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 5-12-49		24c. NAME OF CEMETERY OR CREMATORY Old St. Peters & Paul Cemetery, St. Louis, Mo.		24d. LOCATION (City, town, or county) (State) _____	
DATE REC'D BY LOCAL REG. MAY 11 1949		REGISTRAR'S SIGNATURE J. B. Sauter		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Goodhart & Goodhart 2228 St. Louis Ave.			

(Licensed Embalmer's Statement on Reverse Side)

Ave.

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

300
48

mul

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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed

Charles E. Goodhead

Licensed Embalmer No. *2777*

P. O. Address *St Louis Mo*

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

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