

FILED MAY 28 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17976

BIRTH NO. REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 2002 Registrar's No. 1139

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

1. PLACE OF DEATH a. COUNTY ST. LOUIS COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death.) a. STATE MO b. COUNTY ST. LOUIS	
b. CITY (If outside corporate limits, write RURAL and give township) UNIVERSITY CITY		c. CITY (If outside corporate limits, write RURAL and give township) UNIVERSITY CITY	
c. LENGTH OF STAY (In table place) 1		d. STREET ADDRESS (If rural, give location) 7212 FORSYTHE BLVD	
d. FULL NAME OF HOSPITAL OR INSTITUTION #7212 FORSYTHE BLVD			

3. NAME OF DECEASED (Type or Print) ROBERT E. HENNESSY	(First) (Middle) (Last)	4. DATE OF DEATH MAY 8 1949
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH AUG 24 - 1882	9. AGE (In years last birthday) 66	IF UNDER 1 YEAR Months Days	IF UNDER 1 YEAR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED	10b. KIND OF BUSINESS OR INDUSTRY TERMINAL R.R.	11. BIRTHPLACE (State or foreign country) MO	12. CITIZEN OF WHAT COUNTRY? 0
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13a. FATHER'S NAME WILLIAM HENNESSY	13b. MOTHER'S MAIDEN NAME ELLA LANG	14. NAME OF HUSBAND OR WIFE HANNE HENNESSY
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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 Mrs Anne Hennessy	ADDRESS
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 yrs 2 yrs
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) MALIGNANT GLIOMA BRAIN		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) NONE None DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. NONE none		193X	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION Malignant Glioma of brain MALIGNANT GLIOMA BRAIN	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from July 1947 to MAR 1949, that I last saw the deceased alive on MAY 6, 1949, and that death occurred at July 4, 1949 m., from the causes and on the date stated above.

23a. SIGNATURE Dr. C. H. Lindeman M.D.	(Degree or title)	23b. ADDRESS 426 Shreve Avenue An	23c. DATE SIGNED MAY 9 1949
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE MAY 10 1949	24c. NAME OF CEMETERY OR CREMATORY CALVARY CEM	24d. LOCATION (City, town, or county) (State) ST. LOUIS MO
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DATE REC'D BY LOCAL REG. 5-9-49	REGISTRAR'S SIGNATURE Thurmond L. ...	25. FUNERAL DIRECTOR'S SIGNATURE L. MULLEN UND. CO	ADDRESS 5165 DELMAR
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OCT 15 1949

NOV 8 1949

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.

Signed H. G. Farris

Signed _____
Student Embalmer

Licensed Embalmer No. 3384

P. O. Address. H. Farris

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.