

FILED JAN 16 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

2312  
State File No. ....  
5

318 1003

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. \_\_\_\_\_ PRIMARY REG. DIST. NO. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)<br>a. STATE<br>Missouri |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>OR<br>TOWN<br>St. Louis |  | c. CITY (If outside corporate limits, write RURAL and give township)<br>OR<br>TOWN<br>St. Louis                |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br>IOIE Tamm Ave.                                       |  | d. STREET ADDRESS (If rural, give location)<br>IOIE Tamm Ave.  |  |

|                                     |                    |                        |                        |                            |
|-------------------------------------|--------------------|------------------------|------------------------|----------------------------|
| 3. NAME OF DECEASED (Type or Print) | a. (First)<br>John | b. (Middle)<br>Francis | c. (Last)<br>Bresnahan | 4. DATE OF DEATH<br>I/1/50 |
|-------------------------------------|--------------------|------------------------|------------------------|----------------------------|

|                |                           |   |                               |                                       |                           |                         |                          |                         |
|----------------|---------------------------|---|-------------------------------|---------------------------------------|---------------------------|-------------------------|--------------------------|-------------------------|
| 5. SEX<br>Male | 6. COLOR OR RACE<br>White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br>Married | 8. DATE OF BIRTH<br>7/10/1880 | 9. AGE (In years last birthday)<br>69 | IF UNDER 1 YEAR<br>Months | IF UNDER 1 YEAR<br>Days | IF UNDER 1 YEAR<br>Hours | IF UNDER 1 YEAR<br>Min. |
|----------------|---------------------------|---|-------------------------------|---------------------------------------|---------------------------|-------------------------|--------------------------|-------------------------|

|  |   |   |                              |
|--|---|---|------------------------------|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Checker | 10b. KIND OF BUSINESS OR INDUSTRY<br>Wabash R.R.Co. | 11. BIRTHPLACE (State or foreign country)<br>St. Louis, Mo. | 12. CITIZEN OF WHAT COUNTRY? |
|--|---|---|------------------------------|

|                               |                                      |   |
|-------------------------------|--------------------------------------|---|
| 13a. FATHER'S NAME<br>Unknown | 13b. MOTHER'S MAIDEN NAME<br>Unknown | 14. NAME OF HUSBAND OR WIFE<br>Sabina Bresnahan |
|-------------------------------|--------------------------------------|---|

|  |                         |   |                           |
|--|-------------------------|---|---------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br>No | 16. SOCIAL SECURITY NO. | 17. INFORMANT'S SIGNATURE OR NAME<br>Sabina Bresnahan | ADDRESS<br>IOIE Tamm Ave. |
|--|-------------------------|---|---------------------------|

|   |  |  |   |
|---|--|--|---|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)<br><i>Acute Coronary Occlusion</i>  |  | INTERVAL BETWEEN ONSET AND DEATH<br><i>Sudden</i> |
|   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <i>Chronic Hypertension of Heart Disease</i> |  |   |
|   | DUE TO (c) <i>Chronic Hypertension &amp; Arteriosclerosis</i>  |  |   |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.<br><i>Angina Pectoris</i>   |  |  |   |

|                        |                                  |   |
|------------------------|----------------------------------|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" 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)<br>91 |
|--|--|---|

|  |  |   |
|--|--|---|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR?<br><i>4501</i> |
|--|--|---|

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at \_\_\_\_\_, from the causes and on the date stated above.

|  |   |                                   |
|--|---|-----------------------------------|
| 23a. SIGNATURE (Degree or title)<br><i>Joseph P. Kohler M.D.</i> | 23b. ADDRESS<br><i>4768 Delmar Ave.</i> | 23c. DATE SIGNED<br><i>1/1/50</i> |
|--|---|-----------------------------------|

|   |                     |  |   |
|---|---------------------|--|---|
| 24a. BURIAL CREMATION-REMOVAL (Specify)<br>Burial | 24b. DATE<br>1/1/50 | 24c. NAME OF CEMETERY OR CREMATORY<br>Calvary Cemetery | 24d. LOCATION (City, town, or county) (State)<br>St. Louis, Mo. |
|---|---------------------|--|---|

|  |   |   |                        |
|--|---|---|------------------------|
| DATE REC'D BY LOCAL REG.<br>JAN 3 1950 | REGISTRAR'S SIGNATURE<br><i>J. B. Casater</i> | 25. FUNERAL DIRECTOR'S SIGNATURE<br>Sullivan Funeral Dir. | ADDRESS<br>2849 Euclid |
|--|---|---|------------------------|

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

**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

*Gustav W. Dutala*

Licensed Embalmer No.

*4379*

P. O. Address

*St Louis Mo*

**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.