

FILED NOV 2 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35409**
Registrar's No. **9121**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD 09/28/12
#8.9 amended by affidavit of grandson & decedent's Ireland birth record mjd

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2079	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's Hospital		d. STREET ADDRESS (If rural, give location) 4540 Carter	

3. NAME OF DECEASED (Type or Print)	a. (First) Michael	b. (Middle) J.	c. (Last) Mohan	4. DATE OF DEATH (Month) (Day) (Year) Oct. 15, 1951
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 13, 1865	9. AGE (In years last birthday) 72 86	# UNDER 1 YEAR 3	# UNDER 5 HRS. 3	# UNDER 15 MIN. 3
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Police officer	10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (State or foreign country) Ireland	12. CITIZEN OF WHAT COUNTRY? 4
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13a. FATHER'S NAME Anthony Mohan	13b. MOTHER'S MAIDEN NAME Bridget Burke	14. NAME OF HUSBAND OR WIFE Catherine
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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 Catherine Mohan	ADDRESS 4540 Carter
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 5 years.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardio-vascular Renal Disease		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Disease		
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 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 type="checkbox"/>	21f. HOW DID INJURY OCCUR? 442X
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22. I hereby certify that I attended the deceased from **July 1, 1951**, to **Oct. 15, 1951**, that I last saw the deceased alive on **Oct 14, 1951**, and that death occurred at **3:15 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE John J. Hennelly M.D.	(Degree or title)	23b. ADDRESS 16 Hampton Village Plaza	23c. DATE SIGNED 10/15/51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10/17/51	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. OCT 16 1951	REGISTRAR'S SIGNATURE Paul Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Chas. F. Stuart	ADDRESS 1225 Union
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Thompson Willard

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 *Clement McHenry*

Licensed Embalmer No. *3732*

P. O. Address *St. Louis*

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.