

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500 Registrar's No. 2445

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS COUNTY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>JEFF. BRKS. MO.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS</u> <u>2199</u>	
c. LENGTH OF STAY (in this place) <u>93 Days</u>		d. STREET ADDRESS (If rural, give location) <u>3963 WEST PINE</u> <u>19</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>VET. ADM. HOSP.</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>FRANCIS</u>		b. (Middle) <u>E.</u>		c. (Last) <u>HOLLERAN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>9/19/52</u>	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>9/21/96</u>	
9. AGE (In years last birthday) <u>55 yrs.</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fork Lift Operator</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>ST. LOUIS, MISSOURI</u> <u>0</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	

13a. FATHER'S NAME <u>THOMAS HOLLERAN</u>		13b. MOTHER'S MAIDEN NAME <u>MARGARET DEPEW</u>		14. NAME OF HUSBAND OR WIFE <u>NONE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WORLD I</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT'S SIGNATURE OR NAME <u>V. A. HOSPITAL RECORDS</u> ADDRESS _____	

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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>GASTRO-JEJURO-COLIC FISTULA</u>		INTERVAL BETWEEN ONSET AND DEATH
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ <u>545X</u>		
		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 checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>NONE</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>V.A.</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____	

22. I hereby certify that I attended the deceased from 6/18, 1952, to 9/19, 1952, and that death occurred at 8:20 P m., from the causes and on the date stated above.

23a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>M.D.</u>		23b. ADDRESS <u>V.A. HOSPITAL JEFF. BRKS. MO.</u>		23c. DATE SIGNED <u>(9/19/52)</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>Sept 23 1952</u>		24c. NAME OF CEMETERY OR CREMATORY <u>CHALVARY CEMETERY</u>	
				24d. LOCATION (City, town, or county) (State) <u>ST LOUIS MO</u>	

DATE REC'D BY LOCAL REG. <u>9-22-52</u>		REGISTRAR'S SIGNATURE <u>Herbert R. Donke MD</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>JOSEPH A. HOWARD</u> ADDRESS <u>1619 S. Grand Bl.</u>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1000

REC'D OCT 19 1952

**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

*J. Wm. B. Embury*

Licensed Embalmer No. *3653*

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.