

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

2927

FILED FEB 11 1953

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. <u>1111</u>	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MO</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis, Missouri</u>		c. LENGTH OF STAY (In this place) <u>21</u>		c. CITY (If outside corporate limits, write RURAL and give township) TOWN <u>ST LOUIS</u>		2219	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis City Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>FATHER DEMPSEY'S HOME</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>PAUL</u>		b. (Middle) <u>W.</u>		c. (Last) <u>CALLAHAN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>JANUARY 30, 1953</u>	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>SINGLE</u>		8. DATE OF BIRTH <u>OCT 19 1896</u>	
9. AGE (In years last birthday) <u>56</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NOT NONE</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>ST LOUIS MO</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U</u>		13a. FATHER'S NAME <u>TIMOTHY CALLAHAN</u>		13b. MOTHER'S MAIDEN NAME <u>MARY E HOBAN</u>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Loretta Callahan</u>		ADDRESS <u>4600 Arsenal</u>	
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) <u>Bronchopneumonia</u> <u>right lung</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) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>tuberculosis of left lung, chronic</u> <u>thoracoplasty, left chest</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES ☐ NO ☒			
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)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐		21f. HOW DID INJURY OCCUR? <u>491XA</u>			
22. I hereby certify that I attended the deceased from <u>1-28-53</u> , 19 <u>53</u> , to <u>1-30-53</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>1-30-53</u> , 19 <u>53</u> , and that death occurred at <u>2:00A</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>John H. Wallace M.D.</u>		(Degree or title)		23b. ADDRESS <u>1515 Lafayette Avenue</u>		23c. DATE SIGNED <u>1-30-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>Jan 31-1953</u>		24c. NAME OF CEMETERY OR CREMATORY <u>CALVARY CEM.</u>		24d. LOCATION (City, town, or county) (State) <u>ST LOUIS MO</u>	
DATE REC'D BY LOCAL REG. <u>JAN 30 1953</u>		REGISTRAR'S SIGNATURE <u>J. C. Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. U.C.</u>		ADDRESS <u>1905 S Grand</u>	

(Licensed Embalmer's Statement on Reverse Side)

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 _____

Ronald O. Yachale

Licensed Embalmer No. _____

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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.