

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30219**
Registrar's No. **7533**

FILED AUG 31 1953

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY 2239	
b. CITY OR TOWN St. Louis, Missouri		c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
c. LENGTH OF STAY (in this place)		e. STREET ADDRESS (If rural, give location) 1339 South Broadway Blvd., 23	
d. FULL NAME OF HOSPITAL OR INSTITUTION: 1339 South Broadway Blvd.			

3. NAME OF DECEASED (Type or Print) a. (First) John b. (Middle) Kealy c. (Last) Maher			4. DATE OF DEATH (Month) (Day) (Year) July 30, 1953		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug. 29 1892	9. AGE (In years last birthday) 59	IF UNDER 1 YEAR: Months _____ Days _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Showman	10b. KIND OF BUSINESS OR INDUSTRY Amusement	11. BIRTHPLACE (City and State or Foreign Country) Alpena, Michigan	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME John Maher	13b. MOTHER'S MAIDEN NAME Margaret Kealy	14. NAME OF HUSBAND OR WIFE Harriet Maher
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. Nil	17. INFORMANT'S SIGNATURE OR NAME Harriet Maher	ADDRESS 1339 South Broadway
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (e)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) METASTATIC CARCINOMA		DUE TO (b) _____		6 MONTHS
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		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 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) 1657
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?

22. I hereby certify that I attended the deceased from **7-29**, 19**53**, to **7-31**, 19**53**, that I last saw the deceased alive on **7-30**, 19**53** and that death occurred at **12:30 Am.**, from the causes and on the date stated above.

23a. SIGNATURE Stanley M. Haldo (Degree or title)	23b. ADDRESS 457 N. Kingshighway	23c. DATE SIGNED 7-31-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Entombment	24b. DATE 8-3-53	24c. NAME OF CEMETERY OR CREMATORY Valhalla Mausoleum	24d. LOCATION (City, town, or county) (State) St. Louis County, Missouri
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DATE REC'D BY LOCAL REG. AUG 3 1953	REGISTRAR'S SIGNATURE Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe	ADDRESS 4700 Washington Blvd
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Primary embalmers
secondary
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.....
Signature of Student Embalmer

Signed *John S. Henne*.....
Licensed Embalmer No. *4194*.....
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.