

FILED NOV 22 1954

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

State File No. **38606**  
Registrar's No. **8678**

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 <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis, Mo.</b>		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN <b>Lemay 486</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>DePaul Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>751 Dallas Dr.</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>James J.</b> b. (Middle) <b>Callahan</b> c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) <b>Sept. 22, 1954</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>Jan. 20, 1894</b>	9. AGE (In years last birthday) <b>60</b>	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME <b>James J. Callahan</b>	13b. MOTHER'S MAIDEN NAME <b>Margaret Carey</b>	14. NAME OF HUSBAND OR WIFE <b>Marie C. Callahan</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT'S SIGNATURE OR NAME <b>Marie C. Callahan</b>	ADDRESS <b>751 Dallas Dr. Lemay 23, Mo.</b>
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>some years</b>
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <b>Acute Cardio Decomp.</b>		
	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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>54 22 54 4200</b>
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22. I hereby certify that I attended the deceased from **Sept 15, 1954** to **Sept 22, 1954**, that I last saw the deceased alive on **Sept 1, 1954**, and that death occurred at **540a m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>F. J. Finnegan M.D.</b>	(Degree or title)	23b. ADDRESS <b>539 N. Grand</b>	23c. DATE SIGNED <b>9/23/54</b>
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24a. BURIAL, CREMATION REMOVAL (Specify) <b>removal</b>	24b. DATE <b>9-25-54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive Cem.</b>	24d. LOCATION (City, town, or county) (State) <b>Lemay 23, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>SEP 23 1954</b>	REGISTRAR'S SIGNATURE <b>Carl Smith, Mo.</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Southern Funeral Home</b>	ADDRESS <b>6322 S. Grand Blvd. St. Louis, Mo.</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

No. 300  
10.48

Dr. F. D. Finnegan  
539 N Grand  
9512

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 *David T. Johnson*.....

Licensed Embalmer No. *124*

P. O. Address *6327 1/2*

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.