

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED DEC 12 1955

38730

State File No. 10393

318

1003

BIRTH NO. REG. DIST. NO. PRIMARY REG. DIST. NO. Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) 7 yrs 10 mo.		e. STREET ADDRESS (If rural, give location) 5800 Arsenal St. 20370	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Chronic Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Catherine b. (Middle) Pirosh c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) Nov. 20 1955		
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 4-1-1887	9. AGE (In years last birthday) 68	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Ireland	12. CITIZEN OF WHAT COUNTRY? Unknown
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13a. FATHER'S NAME Francis Flannigan	13b. MOTHER'S MAIDEN NAME Catherine Regan	14. NAME OF HUSBAND OR WIFE George
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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 Hospital Records	ADDRESS 5800 Arsenal St.
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) <i>Lobar Pneumonia;</i>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <i>Fracture of right hip; suffered in fall to floor</i>		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Chronic Hospital on</i>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <i>Sept 26 1955 about 12:15 pm</i>	19c. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT OR SUICIDE? <i>Accident</i>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Street</i>	21c. CITY, TOWN, OR TOWNSHIP (COUNTY) (STATE) <i>St Louis Mo</i>
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21d. TIME OF INJURY <i>Sept 26 55 12:15</i>	21e. INJURY OCCURRED WHILE AT WORK? (Specify) WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <i>fall</i> E903-7
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22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at *10:00* a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <i>Catriek P. Taylor Carover</i>	23b. ADDRESS 1300 Clark Ave.	23c. DATE SIGNED 11-29-55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	24b. DATE 11-29-55	24c. NAME OF CEMETERY OR CREMATORY City Crematory	24d. LOCATION (City, town, or county) (State) St. Louis, Missouri
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DATE REC'D BY LOCAL REG. NOV 29 1955	REGISTRAR'S SIGNATURE <i>Paul Smith Mo</i>	25. FUNERAL DIRECTOR'S SIGNATURE J. Ryan	ADDRESS 5800 Arsenal St.
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(Licensed Embalmer's Statement on Reverse Side)

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

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**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..

NOT EMBALMED      CREMATED BY CITY

Student.....  
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.