

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-030544  
STATE FILE NUMBER

FILED SEP 8 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar No. 8216

|  |                                  |   |  |  |   |
|--|----------------------------------|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY   |                                  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Missouri b. COUNTY |  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN St. Louis  |                                  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   | c. CITY<br>OR<br>TOWN St. Louis  |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                           |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR<br>INSTITUTION Jewish Hospital  |                                  |   | Length of stay in 1b   | STREET ADDRESS (If outside, give location)<br>5949 Era Ave.  |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First JAMES Middle ROBERT Last HORAN   |                                  |   | 4. DATE OF DEATH<br>Month Aug. Day 22, Year 1958   |  |   |
| 5. SEX<br>Male <input checked="" type="checkbox"/>   | 6. COLOR OR RACE<br>White        | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br>July 13, 1899  | 9. AGE (In years last birthday)<br>59                        | IF UNDER 1 YEAR<br>Months Days Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Mailman   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br>U. S. Post Office  |  | 11. BIRTHPLACE (City and state or country)<br>St. Louis, Mo. | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |
| 13. FATHER'S NAME<br>James R. Horan  |                                  |   | 14. MOTHER'S MAIDEN NAME<br>Annie McEnaney   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br>no none  |                                  | 16. SOCIAL SECURITY NO.<br>* * * *  | 17. INFORMANT<br>Address<br>Lucille Horan 5949 Era Ave.  |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <del>_____</del> Lymphosarcoma  |                                  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br>4 1/2 years   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.   |                                  |   |  |  | DUE TO (b) _____  |
| DUE TO (c) _____   |                                  |   |  |  | 200.1   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2 |
| 20a. ACCIDENT <input type="checkbox"/>   | SUICIDE <input type="checkbox"/> | HOMICIDE <input type="checkbox"/>   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                         |  |   |
| 20c. TIME OF INJURY<br>Hour a. m. p. m.<br>Month, Day, Year  |                                  |   |  |  |   |
| 20d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                                  | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)   |  | 20f. CITY, TOWN, OR LOCATION COUNTY STATE                    |   |
| 21. I attended the deceased from Oct. 22, 1947, to Aug 22, 1958 and last saw him alive on Aug 22, 1958<br>Death occurred at 5:30 A. m on the date stated above; and to the best of my knowledge, from the causes stated. |                                  |   |  |  |   |
| 22a. SIGNATURE<br>Bernard Friedman, M.D.   |                                  |   | 22b. ADDRESS<br>539 N. Grand   |  | 22c. DATE SIGNED<br>8-23-58   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  | 23b. DATE                        | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City, town, or county) (State)                |   |
| Burial   | 8/25/58                          | Calvary Cemetery  |  | St. Louis, Missouri.   |   |
| 24. FUNERAL DIRECTOR<br>JOHN STEGAR & SON = 5341 RIVERVIEW BLVD.   |                                  |   | 25. DATE RECD. BY LOCAL REG.<br>AUG 25 '58   | 26. REGISTRAR'S SIGNATURE<br>J. Earl Smith, M.D.<br>S.P.     |   |

(Licensed Embalmer's Statement on Reverse Side)

Health, & Welfare Public Service

300 1-56

doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.....  
*J. W. Rister*

Licensed Embalmer No. *39*

P. O. Address *St. Louis*

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.