

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Harrigan & Sheahan

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

REC'D FEB 10 1939

275  
Do not use this space.  
275

1. PLACE OF DEATH

(a) County ..... Registration District No. 791  
1003  
(b) Township ..... Primary Registration District No. .... Registered No. ....  
or St. Louis  
(c) City ..... (d) Street No. City Hospital No. 1 St.  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 636 Helen Cortor  
3950 Kennerly St. 11  
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female  
4. COLOR OR RACE white  
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Gordon Cortor

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 23, 1912

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
26 11 14

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as saw mill, bank, etc. hwk  
10. Date deceased last worked at this occupation (month and year)  
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis, Missouri

FATHER 13. NAME Michael Mc Gann

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis, Missouri

MOTHER 15. MAIDEN NAME Mary Ryan

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis, Missouri

17. INFORMANT Hosp. Info M. Kent  
(ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE Calvary Cemt DATE Jan 10th 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Harrigan & Sheahan Und Co  
4415 Washington Blvd.

20. FILED JAN 9 1939 J. B. Brudek Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1/7/39 19

22. I HEREBY CERTIFY, That I attended deceased from 12/26/38, 19 to 1/7/39, 19

I last saw him alive on 1/7/39, 19. Death is said to have occurred on the date stated above, at 5 a.m.

The principal cause of death and related causes of importance were as follows:

Bacterial Endocarditis  
Septicemia  
Pulmonary edema

Other contributory causes of importance:

145a

Name of operation Carcinoma Section Date of 12/28/39

What test confirmed diagnosis? Was there an autopsy? YES

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) John F. Flynn, M. D.

(Address) City Hospital No. 1

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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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed

*Albert G. Nappa*

Licensed Embalmer No. *2971*

P. O. Address.....

**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, above space should be left blank.**