

REC'D JUN 12 1939

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

791  
1008

17083  
Do not use this space.

4617

1. PLACE OF DEATH

(a) County ..... Registration District No. ....  
(b) Township ..... Primary Registration District No. .... Registered No. ....  
(c) City St. Louis or ..... (d) Street No. St. John Hospital ..... 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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Elizabeth G. Tulley

(a) Residence, No. 1231 Oakley Pl. ..... St. 5 ..... (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

Female White Widowed

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

Matthew Tulley

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Don't Know

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
About 81

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired  
9. Industry or business in which work was done, as saw mill, bank, etc.  
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) New York

FATHER 13. NAME John Gravin

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

MOTHER 15. MAIDEN NAME Don't Know

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

17. INFORMANT John D. Tulley (ADDRESS) 1231 Oakley Pl.

18. BURIAL, CREMATION, OR REMOVAL PLACE Adams, New York DATE May 21/39

19. FUNERAL DIRECTOR (NAME) Jos. W. Clark (ADDRESS) 1125 Hodiamont Ave.

20. FILED MAY 21 1939

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 20/39 . 19

22. I HEREBY CERTIFY, That I attended deceased from 5/10/39, 19, to 5/20/39, 19. I last saw him alive on 5/20/39, 19. Death is said to have occurred on the date stated above, at 12:15 A.M.  
The principal cause of death and related causes of importance were as follows:

Pneumonia  
the type pneumonia  
Cocaine type

Other contributory causes of importance:

Name of operation ..... Date of .....  
What test confirmed diagnosis? ..... Was there an autopsy? NO

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? ..... Date of injury .....  
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) D. J. Clark M. D.  
(Address) 1125 Hodiamont Ave.

WHITE CARBON, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

1 X16605

Dr. O. P. J. Falk,  
36 04 Washington Ave.,  
Je. 1800.

11-2-61

**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..... *Gas. W. Clark*.....  
Licensed Embalmer No..... 1661.....

P. O. Address 1125 Hodiament Ave.,

**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.