

JAN 12 1940

11151

Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
 (b) City or town ST. LOUIS
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
CITY HOSPITAL
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 7 HOURS
 In this community 67 YRS. 8 MOS. 20 DAS.
 (Specify whether years, months or days)

8. (a) PRINT FULL NAME LETTIA MC COLGAN 2428. (b) If veteran, name war NO 8. (c) Social Security No. NO4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWED6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive _____ years7. Birth date of deceased APR. 20, 1872
(Month) (Day) (Year)8. AGE: Years 67 Months 8 Days 26 If less than one day hr. _____ min. _____9. Birthplace ST. LOUIS MO.
(City, town, or county) (State or foreign country)10. Usual occupation HOUSEWORK

11. Industry or business _____

12. Name UNKNOWN13. Birthplace UNKNOWN
(City, town, or county) (State or foreign country)14. Maiden name UNKNOWN15. Birthplace IRELAND
(City, town, or county) (State or foreign country)16. (a) Informant's own signature William M. Colgan(b) Address 1436A DODIER ST17. (a) BURIAL (b) Date thereof DEC. 28, 1939
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation CALVARY CEMETERY18. (a) Signature of funeral director Robert J. Cochrane(b) Address 2228 ST. LOUIS AVE19. (a) DEC 28 1939 (b) J. B. Radtke
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County _____
 (c) City or town ST. LOUIS 26
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1436A DODIER ST
NO PHYSICIAN IN ATTENDANCE (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 26th
year 1939 hour 8:00 minute A. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death Cholelithiasis;
Hepatolithiasis; Arterio Sclerosis;

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 8 months of death)Major findings: _____
Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____ (Specify type of place) (e) Means of injury 423. Signature Walter J. Perry (M. D. or other) _____Address City of St. Louis Date signed 12.28.39

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

Charles Goodhart
.....
Licensed Embalmer No. *2777*
.....
P. O. Address *Howe Ms*
.....

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.