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S. No. 2  
-11-10-39  
-5-17-39  
-1 X21

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

13498

State File No. \_\_\_\_\_

FILED MAY 15 1940

3700

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County \_\_\_\_\_

(b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: City Hospital, #1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 Day (Specify whether  
In this community 1 Day  
years, months or days)

3. (a) PRINT FULL NAME Baby McCullen 245

8. (b) If veteran, name war No

8. (c) Social Security No. Unknown

4. Sex Female race White

5. Color or race \_\_\_\_\_

6. (a) Single, widowed, married, divorced Single

6. (c) Age of husband or wife if alive Single years

7. Birth date of deceased March 31, 1940  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

1 hr. \_\_\_\_\_ min.

9. Birthplace St. Louis, Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Nil.

11. Industry or business Nil.

MOTHER { 12. Name Eugene McCullen

FATHER { 18. Birthplace Missouri  
(City, town, or county) (State or foreign country)

MOTHER { 14. Maiden name Gertrude Georgen

FATHER { 15. Birthplace Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Ann [unclear]

(b) Address City Hospital, #1

17. (a) Cremation (b) Date thereof 4-26-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Crematory City

18. (a) Signature of funeral director W. H. White

(b) Address City Hospital, #1

19. (a) APR 24 1940 (b) J. F. [unclear]  
(Date received local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_

(c) City or town St. Louis, Missouri 26  
(If outside city or town limits, write "RURAL")

(d) Street No. 2108a Destrahan  
(If rural, give location)

(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 1,  
year 1940 hour 3:00 minute \_\_\_\_\_ A. M.

21. I hereby certify that I attended the deceased from March 31, 1940, to April 1, 1940, that I last saw her alive on April 1, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Intra-Cranial Hemorrhage  
Non-traumatic

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) None

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 \_\_\_\_\_

23. Signature John F. Flynn (M. D. or other) \_\_\_\_\_

Address 1015 Lafayette Date 4/1/40

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

1978 12 14 11:11 AM

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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.....

Licensed Embalmer No.....

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.**