

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

SEP 25 1940
Registration District No. **791**

Primary Registration District No. **1003**

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:
De. Paul Hospital.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **Three Hours.**
(Specify whether _____)
In this community **Life Time.**
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

0
(a) State **Missouri** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limit: write "RURAL") **7**
(d) Street No. **4630 Farlin**
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME **Agnes V. Cullen.** **450**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widow**
6. (b) Name of husband or wife **John Cullen** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **April 29, 1880.**
(Month) (Day) (Year)

8. AGE: Years **60** Months **23** Days **21** If less than one day _____ hr. _____ min.

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

10. Usual occupation **At Home**

11. Industry or business _____

MOTHER FATHER { 12. Name **Nicholas Byrne.**
18. Birthplace **Ireland**
(City, town, or county) (State or foreign country)
14. Maiden name **Catherine O'Brien**
15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **John Cullen.**
(b) Address **4630 Farlin.**

17. (a) **Burial** (b) Date thereof **Aug. 24, 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **Stroot Carroll**
(b) Address **4600 Natural Bridge**

19. (a) **AUG 22 1940** (b) **J. F. Prueck**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug.** day **20**
year **1940** hour **16** minute **35 P.** M.

21. I hereby certify that I attended the deceased from **Aug 16**, 19**40** to **Aug 20**, 19**40**
that I last saw **her** alive on **Aug 20**, 19**40**
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Myelogenous Leukemia (Subacute)
Due to _____

Due to **Myelogenous Leukemia (Subacute)**

Other conditions (Include pregnancy within 3 months of death) _____
Anemia Secondary.
Major findings: _____
Of operations _____

Of autopsy _____

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 **E. J. Javary** (M. D. or other) _____
Address **607 No. Hand** Date signed **8-21-40**

Duration **2 or 3 mo**
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

Sheldon Collier

Licensed Embalmer No.

3382

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.