

No. 2
1-5-43
5-17-39
X36671

FILED FEB 7 1944

Registration District No. 317

Primary Registration District No. 3069

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Richmond Heights
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Mary's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED: 000

(a) State Missouri (b) County 17

(c) City or town St. Louis
(If outside city or town limits, write "RURAL") 9

(d) Street No. 2311 Russell Blvd
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME ANNIE C. Mary Cullen Brown

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 Married

6. (b) Name of husband or wife Edward Brown

6. (c) Age of husband or wife if alive 84 years

7. Birth date of deceased October 20 1871
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>72</u>	<u>3</u>	<u>11</u>	hr. _____ min.

9. Birthplace Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name John Cullen

13. Birthplace Ireland
(City, town, or county) (State or foreign country)

14. Maiden name Mary Ann Sheehan

15. Birthplace Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant Philip C. Brown

(b) Address 2311 Russell Blvd

17. (a) Burial
(Burial, cremation, or removal)

(b) Date thereof Feb 3 1944
(Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Petz Brothers

(b) Address 3029 Lafayette Ave

19. (a) FEB 2 - 1944
(Date received local Registrar)

(b) E. G. McCarren, M.D.
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 31st day January
year 1944 hour 2:00 minute P. M.

21. I hereby certify that I attended the deceased from 12/15/43 19____ to 1/31/44 19____
that I last saw h. alive on 1/30/44 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral palsy (3)
low

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy 1/90

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 0

23. Signature W. J. Kelly (M. D. or other) Med
Address Shubert St. Kelly Date signed 7/1/44

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

MOTHER FATHER

FEB 2 8 1944

FEB 16 1944

*Dr. J. C. ...
Amended 1944
Jan 18 1948
1 PM*

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 *Francis J. Quinn*
Licensed Embalmer No. *7245*
P. O. Address *At Home*

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, fact should be so stated above.

FEB 2 8 1944

NOV 13 1944



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