

FILED APR 20 1944

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **3372**

1. PLACE OF DEATH:

(a) County **ST. LOUIS**
 (b) City or town **ST. LOUIS**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
MO. PACIFIC Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)
 In this community **3 DAYS**

3. (a) PRINT FULL NAME **Mamie Costello**
 3. (b) If veteran, name war **NO**
 3. (c) Social Security No. **NONE**

4. Sex **F** 5. Color or race **W**
 6. (a) Single, widowed, married, divorced **MARRIED**
 6. (b) Name of husband or wife **D.V. COSTELLO**
 6. (c) Age of husband or wife if alive **55 years**
 7. Birth date of deceased **Feb. 6 1890**
(Month) (Day) (Year)

8. AGE: Years **54** Months **2** Days **3**
 If less than one day hr. _____ min. _____

9. Birthplace **E. ST. LOUIS ILL**
(City, town, or county) (State or foreign country)

10. Usual occupation **HOUSE WORK**

11. Industry or business **HOUSE WORK**

12. Name **Thomas Delehanty**
 13. Birthplace **England**
(City, town, or county) (State or foreign country)
 14. Maiden name **Jessie McElroy**
 15. Birthplace **Mississippi**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mr Daniel V Costello**
 (b) Address **1924 N 53 St**

17. (a) **BURIAL** (Burial, cremation, or removal)
 (b) Date thereof **4-11-44**
(Month) (Day) (Year)

(c) Place: burial or cremation **M. I. CARMEL**

18. (a) Signature of funeral director **Walter Walsh Barnes**

(b) Address **116 St Louis Ave, East St Louis, Ill**

19. (a) **APR 17 1944** (Date received local registrar)
 (b) **J. F. Bredeck** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **ILL.** (b) County **ST. CLAIR**
 (c) City or town **E. ST. LOUIS**
(If outside city or town limits, write "RURAL")
 (d) Street No. **1924 N 53 St**
(If rural, give location)
 (e) Citizen of foreign country? **NO** (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **9**
 year **1944** hour **7** minute **30 A.M.**
 21. I hereby certify that I attended the deceased from **April 7**, 1944, to **April 9**, 1944
 that I last saw her alive on **April 9**, 1944
 and that death occurred on the date and hour stated above.

Immediate cause of death **Intestinal obstruction**
Ceculity, Gall stone
hypertensive disease
 Due to **Post-operative intestinal hernia**
acute
 Due to _____

Other conditions **1/22**
(Include pregnancy within 3 months of death)

Major findings:
 Of operations **large incarcerated**
intestine flame-
 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 **[Signature]** (M. D. or other) **led**
 Address **no per keep** Date signed **4-22-44**

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

MOTHER FATHER

APR 11 1944

Embalmer report to be filed

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, fact should be so stated above.