

Dr. Meredith 38288
Page *1* State File No. *38288*

Registration District No. *317*

Primary Registration District No. *6076*

Registrar's No. *1709*

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Gardenville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Miller Nursing Home, 48449 Gravois
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 mos. 12 da.
(Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL") 9
(d) Street No. 5655 Kennerly Ave.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Jennie B. Mellick

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Peter P. Mellick

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

7. Birth date of deceased September 11 1861
(Month) (Day) (Year)

8. AGE: Years 82 Months 10 Days 29
If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business

12. Name John Kerrigan

13. Birthplace Unknown Ireland 4
(City, town, or county) (State, or foreign country)

14. Maiden name Ann O'Reilly

15. Birthplace Unknown Ireland 4
(City, town, or county) (State, or foreign country)

16. (a) Informant Louis J. Mellick

(b) Address 5655 Kennerly Ave.

17. (a) Burial (b) Date thereof 8/14/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Stroot-Carroll

(b) Address 4600 Natural Bridge Ave.

19. (a) AUG 14 1944 (b) E. D. McLawren, M.D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 10
year 1944 hour 2 minute _____ A.M.

21. I hereby certify that I attended the deceased from May 28, 1944, to August 10th, 1944,
that I last saw her alive on August 8th, 1944,
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of womb

Due to Myocardial infarction

Due to Terminal influenza

Other conditions (Include pregnancy within 3 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 _____

23. Signature J. G. Meredith (M. D. or other) M.D.
Address 259 N. Highways Date signed _____

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

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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

W. H. Stodds

Licensed Embalmer No. 2265

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.