V. S. No. 2
00M—2-43
ev. 5-17-39
X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

32182

State File No.

FILED NOV 10 1944

Registration District No. 318 Primary Registration District No. 0003 Registrar's No. 8620

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: City Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution D.A. (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 000
(a) State Mo (b) County 17
(c) City or town St. Louis 9
(If outside city or town limits, write "RURAL")
(d) Street No. 3232 Olive St 21
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME Josephine Ford Cullen
3. (b) If veteran, name war None
3. (c) Social Security No.

4. Sex Female 1
5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Sept 19th ~~1934~~ 1910
(Month) (Day) (Year)

8. AGE: Years 34 Months 0 Days 19 If less than one day hr. min.

9. Birthplace St. Louis (City, town, or county) Mo 0 (State or foreign country)
10. Usual occupation Inspector
11. Industry or business Metro Glodman Co

FATHER
12. Name Frank Ford
13. Birthplace St. Louis (City, town, or county) Mo 0 (State or foreign country)

MOTHER
14. Maiden name Ida Jungeman
15. Birthplace (City, town, or county) U.S.A. 1 (State or foreign country)

16. (a) Informant Anna Cullen
(b) Address 7325 Jenwood Ave
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11/44 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemt
18. (a) Signature of funeral director Harnigan & Sheahan Und Co
(b) Address 4415 Washington Blvd
19. (a) OCT 10 1944 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 8 year 1944 hour 1 minutes 30 P.M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Diabetes Mellitus

Due to

Due to 61

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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 Dr. Alfred J. Perry (M. D. or other)
Address Deputy Coroner Date signed 10-10-44

(Licensed Embalmer's Statement on Reverse Side)

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.