V. S. No. 2
00M—5-43
ev. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 16 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 7903

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2074

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: 2811 Madison St.
(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 10 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County

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

(d) Street No. 2811 Madison St.
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Mary A Kilcullen

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

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 Mar 19th. 1865 (Month) (Day) (Year)

8. AGE: Years 79 Months 11 Days 28 If less than one day hr. min.

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

10. Usual occupation A5T Home

11. Industry or business

FATHER
12. Name Thomas Kilcullen
13. Birthplace (City, town, or county) Ireland (State or foreign country)

MOTHER
14. Maiden Ann ??????
15. Birthplace (City, town, or county) Ireland (State or foreign country)

16. (a) Informant Mrs Mamie Hogan

(b) Address 2715 Madison St

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/5/45 (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemt

18. (a) Signature of funeral director Harrigan & Sheahan Und Co

(b) Address 4416 Washington Blvd.

19. (a) MAR 3 1945 (Date received local registrar) (b) J. F. Budech (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 1st. year 1945 hour 8:45 PM. M.

21. I hereby certify that I attended the deceased from Sept 15, 1945 to March 1, 1945 that I last saw him alive on March 1, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage — Duration 1 day

Due to Hypertension

Due to Arterio Sclerosis

Other conditions Senility
(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? (Specify type of place)

While at work? (e) Means of injury

23. Signature A. H. Kraft (M. D. or other)

Address 2416 W. Grand Date signed 3/5/45

(Licensed Embalmer's Statement on Reverse Side)

Dr. Kasell
7-4-66 M Grand

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 Jay Wilkinson

Licensed Embalmer No. 3575

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.