

**FILED** JUL 20 1945  
Registration District No. \_\_\_\_\_

Primary Registration District No. **1003**

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:  
**St. Johns Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **0** (Specify whether  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME **Delia Brabazon**

3. (b) If veteran, name war \_\_\_\_\_ 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 **James A. Brabazon** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **February 24 1880**  
(Month) (Day) (Year)

8. AGE: Years **65** Months **4** Days **18** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace **St. Louis Missouri**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business \_\_\_\_\_  
12. Name **John Cottle**

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

14. Maiden name **Bridget Higgins**

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

16. (a) Informant **Mrs. C. Kamp**  
(b) Address **4453 San Francisco Ave.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **7/16/45**  
(Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Stroot-Carroll**

18. (a) Signature of funeral director **J. F. Bulech**  
(b) Address **4600 Natural Bridge Ave.**

19. (a) **JUL 14 1945** (Data received local registrar) (b) **J. F. Bulech** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County \_\_\_\_\_  
(c) City or town **St. Louis**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **4453 San Francisco Ave.**  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **12**  
year **1945** hour **11** minute **40 P.** M.

21. I hereby certify that I attended the deceased from **7-9-45**  
\_\_\_\_\_ 19\_\_\_\_ to **7-12** 19\_\_\_\_  
that I last saw her alive on **7-12** 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death **Concussion of brain**  
Due to **Diabetic Coma**

Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 1 month of death)

Major findings: **None**  
Of operations \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_

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 **W. J. Gallagher** (M. D. or other) **MD**  
Address **6742 Grand** Date signed **7-13-45**

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

MOTHER FATHER

**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

*Ben E. Hoffman*

Licensed Embalmer No. *4366*

P. O. Address *Louis, MO*

**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.**