

S. No. 2
DM-5-43
v. 5-17-39
I X36671

DEPARTMENT OF HEALTH OF THE STATE OF MISSOURI
BUREAU OF THE CENTRAL REGISTER
FILED SEP 7 1945 STANDARD CERTIFICATE OF DEATH

25973

State File No. _____
Registrar's No. 7407-

Registration District No. 318 Primary Registration District No. 1003

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

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:
5312 Ridge Ave. /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME Margaret Mulholland.
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F. / race W. 5. Color or race _____
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife James J. Mulholland. 6. (c) Age of husband or wife if alive 90 years
7. Birth date of deceased August 3, 1865
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>80</u>	<u>0</u>	<u>22</u>	_____ hr. _____ min.

9. Birthplace St. Louis, Mo. _____
(City, town, or county) (State or foreign country)
10. Usual occupation At Home.

11. Industry or business _____
12. Name John O'Brien.
13. Birthplace Ireland. _____
(City, town, or county) (State or foreign country)
14. Maiden name Mary Ryan.
15. Birthplace Ireland. _____
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Marie Mulholland.
(b) Address 5312 Ridge Ave.
17. (a) Burial (b) Date thereof 8-27-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery
18. (a) Signature of funeral director Arthur J. Linnelle
(b) Address 3840 Lindell Blvd.
19. (a) AUG 26 1945 (b) J. F. Beasock
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County 000
(c) City or town St. Louis _____
(If outside city or town limits, write "RURAL")
(d) Street No. 5312 Ridge Ave. _____
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Aug. day 25th.
year 1945 hour 5 minute 15 A.M.
21. I hereby certify that I attended the deceased from Aug 24, 1945 to death, 19____
that I last saw her alive on Aug 24-1945 and that death occurred on the date and hour stated above.
Immediate cause of death Cardiac failure -
hemorrhage into Colloid
gout
Due to Vascular changes of
senility - Colloid goiter
Due to primary site
Other conditions _____
(Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy _____
162
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? _____ Means of injury _____
23. Signature R. E. Evans (M. D. or other) _____
Address 2201 N. Rigney Hwy Date signed Aug 25
1, 945

W. Kaplan
230 N. 7th St
111-1

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 Stanley Marshall

Licensed Embalmer No. 2838

P. O. Address 3840 Friedell

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.