

FILED SEP 13 1945 STANDARD CERTIFICATE OF DEATH

State File No. 28312

Registration District No. 310

Primary Registration District No. 3058

Registrar's No. 106

1. PLACE OF DEATH:

(a) County St. Charles

(b) City or town St. Charles
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Joseph Hospital
(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 _____
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Mayme Gilleran

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 Married

6. (b) Name of husband or wife Thomas J. Gilleran

6. (c) Age of husband or wife if alive 72 years

7. Birth date of deceased May 1, 1890
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
55	3	8	hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER

12. Name George Benson

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

14. Maiden name Nora Hollan

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

16. (a) Informant Thomas J. Gilleran

(b) Address O'Fallon, Mo.

17. (a) Burial
(Burial, cremation, or removal)

(b) Date thereof Aug. 11/45
(Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cem. St. Louis

18. (a) Signature of funeral director Jos. W. Clark

(b) Address 1125 Hodiamont Ave.

19. (a) 8-10-1945
(Date received local registrar)

(b) Grant S. Paul
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Charles

(c) City or town O'Fallon
(If outside city or town limits, write "RURAL")

(d) Street No. Rural
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 9th
year 1945 hour _____ minute 10 A. M.

21. I hereby certify that I attended the deceased from April 6, 1945 to August 9, 1945
that I last saw her alive on August 9, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Lymphatic Leukemia long

Due to _____

Due to _____

Other conditions 74
(Include pregnancy within 3 months of death)

Major findings: Ratopneumonial lymphadenitis

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 B. L. Neuberger (M. D. or other) md

Address St. Charles, Mo. Date signed 8/9/45

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

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed.....

9-12-45

Dr. B.L. Neubeliser
St. Charles, Mo.

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.....

Alfred J. Boedecker

Licensed Embalmer No..... 2663

P. O. Address 5934 Alpha Ave.,.....

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.