

FILED MAY 31 1946

1003

Registrar's No. 4598

Registration District No. 318

Primary Registration District No.

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: ST. JOHN'S HOSPITAL  
(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) Daniel Stephen Mullyally

3. (a) PRINT FULL NAME DANIEL STEPHEN MULLALLY

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED  
6. (b) Name of husband or wife. ALICE, T. 6. (c) Age of husband or wife if alive 63 years  
7. Birth date of deceased. 17 (Month) 26 (Day) 1876 (Year)

8. AGE: Years 69 Months 2 Days 25 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace MO. (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_

10. Usual occupation BRAIN BROKER

11. Industry or business DAN S. MULLALLY BRAIN CO.

12. Name DANIEL MULLALLY

13. Birthplace IRELAND (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_

14. Maiden name MARY SHEEHAN

15. Birthplace IRELAND (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_

16. (a) Informant Alice J. Mullyally

(b) Address 371 BRET AV.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof. 5 (Month) 23 (Day) 1946 (Year)

(c) Place: burial or cremation CALVARY CEMETARY

18. (a) Signature of funeral director J. J. Brueck

(b) Address 5105 DELMAR BLVD

19. (a) MAY 22 1946 (Date received local registrar) (b) J. J. Brueck (Registrar's signature)

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. 371 BRET AVENUE (If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 21 year 1946 hour 9:37 AM minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from Sept 7 1945 to May 21 1946  
that I last saw him alive on May 20 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Arterio Sclerotic Heart Disease

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy Obese

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 Phil [illegible] (M. D. or other) \_\_\_\_\_

Address [illegible] Date signed [illegible]

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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

*B. G. Harris*

Licensed Embalmer No.

*3384*

P. O. Address

*St Louis*

**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.**