

No. 2  
12-45  
17-39  
X47070

STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **14965**

**FILED APR 23 1947**

#6205 **818**

Registration District No. \_\_\_\_\_ Primary Registration District No. **1003**

Registrar's No. **3723**

**1. PLACE OF DEATH:**

(a) County..... St. Louis, Missouri.

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

(c) Name of hospital or institution:  
St. Louis City Hospital-Max C. Starkloff  
(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

**2. USUAL RESIDENCE OF DECEASED:**

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

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

(d) Street No. 918 So. Newstead Ave.  
Memorial  
(If rural, give location)

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

If yes, name country.....

**3. (a) PRINT FULL NAME** WILLIAM CULLEN

3. (b) If veteran, name war..... None 3. (c) Social Security No. 492-24-7473

4. Sex Male 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 Aug. 9 1897  
(Month) (Day) (Year)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month April day 7th  
year 1947 hour 12:01 minute A M.

21. I hereby certify that I attended the deceased from 1/20/47  
4/7/47, 19  , to 4/7/47, 19  ;  
that I last saw him alive on 4/7/47, 19  ;  
and that death occurred on the date and hour stated above.

**8. AGE:**

Years	Months	Days	If less than one day
<u>49</u>	<u>7</u>	<u>28</u>	hr. min.

Immediate cause of death Carcinoma of the Transverse Colon with metastases

Due to.....

Due to.....

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

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

10. Usual occupation Maintenance Man

**PHYSICIAN**

Major findings: Same as above

"Of operations.....

Of autopsy..... Same

Underline the cause to which death should be charged statistically.

11. Industry or business Arena

**MOTHER FATHER**

12. Name Michael Cullen

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

14. Maiden name Margaret Britt

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

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?.....

16. (a) Informant Mrs. George Foerstel

(b) Address 3141a Maury Ave.

17. (a) Burial (b) Date thereof 4 10 47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Kriegshauser Und. Co.

(b) Address 4228 So. Kingshighway Bl.

19. (a) APR 8 1947 J. F. Brueck  
(Date received local registrar) (Registrar's signature)

23. Signature J. R. Dalton M.D.

Address 1515 Lafayette

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

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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.....

*Edwin M. Herriott*

Licensed Embalmer No.....

*3024*

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.**