

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

21117

State File No. ....

FILED JUN 21 1948

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 5204

## 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: DePaul Hosp  
 (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 William Mc.Gilligan

3. (b) If veteran, name war..... None 3. (c) Social Security No. ....

4. Sex M 5. Color or race W 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..... (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
alt - 75 ..br. ....min.

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

10. Usual occupation Unemployed

11. Industry or business.....

12. Name James McGilligan

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

14. Maiden name Catherine Daugherty

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

16. (a) Informant Mary McGilligan

(b) Address 5104 Highland

17. (a) Burial (b) Date thereof June 8 48  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Stroot Carroll

(b) Address 4600 Natl. Bridge

19. (a) 1948 7 1948 (b) J. J. Brudeck  
 (Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County nos  
 (c) City or town St. Louis  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 5104 Highland  
6 (If rural, give location)  
 (e) Citizen of foreign country?..... (Yes or No)  
 If yes, name country.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 5  
 year 1948 hour 7 minute 30 a. m.

21. I hereby certify that I attended the deceased from April 21 1948 to June 5 48  
 that I last saw im alive on June 4 1948  
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage 6-5-48

Duration Chronic Myocarditis 6-7-47

Due to arteriosclerosis 6-1-47

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

Major findings: 1/2

Of operations.....

Of autopsy.....

## PHYSICIAN

Underline the cause of 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)

23. Signature Wm. J. Brudeck (M. D. or other) 4600

Address 380 S. W. 1st St. Date signed 6-7-48

MOTHER FATHER

WRITE PLAINLY—USING

**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 \_\_\_\_\_

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.

*July*  
*5204*

Registration District No.

*318*

Primary Registration District No.

*1003*

Registrar's 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:

(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

*Wm Mc Gelligan*

3. (b) If veteran, name war.....

3. (c) Social Security No.....

4. Sex *m* 5. Color or race *w*

6. (a) Single, widowed, married, divorced *s*

6. (b) Name of husband or wife.....

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

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
*at 75* hr. min.

9. Birthplace..... (State or foreign country) *MO*

10. Usual occupation *Self employed*

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a) (Data received local registrar) (b) *J. F. Bredeau* (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....

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

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

(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... Year *1948* Hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... to....., 19.....;

that I last saw him..... alive on....., 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death.....

Duration

Due to.....

Due to.....

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

Major findings: Of operations.....

Of autopsy.....

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..... (M. D. or other)

Address..... Date signed.....

SUPPLEMENTARY

MOTHER FATHER

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

JUN 24 1948

5-21117

1710-0341