

FILED MAR 11 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 1989

6072

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No.

|   |                        |  |  |
|---|------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |                        | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE Missouri<br>b. COUNTY   |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis  |                        | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION 5530 Delmar   |                        | d. STREET ADDRESS (If rural, give location) 5530 Delmar  |  |
| 3. NAME OF DECEASED<br>a. (First) Nellie<br>b. (Middle) Corcoran<br>c. (Last)   |                        |  | 4. DATE OF DEATH (Month) (Day) (Year) Feb. 28 - 1949   |
| 5. SEX Female   | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed   | 8. DATE OF BIRTH 10/14/1882  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife   |                        | 10b. KIND OF BUSINESS OR INDUSTRY  | 9. AGE (In years last birthday) 66<br>IF UNDER 1 YEAR Months Days<br>IF UNDER 24 HRS. Hours Min. |
| 11. BIRTHPLACE (State or foreign country) St. Louis, Mo.  |                        | 12. CITIZEN OF WHAT COUNTRY?   |  |
| 13a. FATHER'S NAME Thomas Burke   |                        | 13b. MOTHER'S MAIDEN NAME Katherine Fox  |  |
| 14. NAME OF HUSBAND OR WIFE Jerry Corcoran  |                        | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |  |
| 16. SOCIAL SECURITY NO.   |                        | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Charlotte Lee 5530 Delmar  |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. |                        | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Rheumatic Heart Disease<br>ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Acute Regurgitation<br>DUE TO (c)<br>II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. |  |
| 19a. DATE OF OPERATION  |                        | 19b. MAJOR FINDINGS OF OPERATION<br>92a<br>H11X  |  |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |                        | 21a. ACCIDENT SUICIDE HOMICIDE (Specify)   |  |
| 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                        | 21c. CITY, TOWN, OR TOWNSHIP (COUNTY) (STATE) St. Louis Mo   |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.  |                        | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |
| 21f. HOW DID INJURY OCCUR?  |                        | 22. I hereby certify that I attended the deceased from 6-15 1939, to 3/28 1949, that I last saw the deceased alive on Feb 28, 1949, and that death occurred at 4:30 p.m., from the causes and on the date stated above.  |  |
| 23a. SIGNATURE (Degree or title) J. G. Drake M.D.   |                        | 23b. ADDRESS 114 No. Taylor  |  |
| 23c. DATE SIGNED 3/1/49   |                        | 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial   |  |
| 24b. DATE 3-3-1949  |                        | 24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery  |  |
| 24d. LOCATION (City, town, or county) (State) St. Louis, Mo.  |                        | DATE REC'D BY LOCAL REG. MAR 2 1949  |  |
| REGISTRAR'S SIGNATURE J. B. Sauter  |                        | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Sullivan Funeral Dir. 2849N. Euclid   |  |

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

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DR. Truman G. Drake  
114 North Taylor Ave.  
JE. 8600

*mit*

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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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_

*Robert L. Brinkman*

Licensed Embalmer No. 3553

Signed \_\_\_\_\_  
Student Embalmer

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.