

FILED MAR 5 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 6082

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 1571

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	c. LENGTH OF STAY (In this place) 2 1/2 yrs	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3617 Kossuth		d. STREET ADDRESS (If rural, give location) 3617 Kossuth	

3. NAME OF DECEASED (Type or Print) Dr. Edward Emanuel Cullen			4. DATE OF DEATH (Month) (Day) (Year) 2-17-1949		
a. (First)	b. (Middle)	c. (Last)			

5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept-25-1900	9. AGE (In years last birthday) 48	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dentist		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) East St. Louis, Ill.		12. CITIZEN OF WHAT COUNTRY?	
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13a. FATHER'S NAME James Cullen		13b. MOTHER'S MAIDEN NAME Elizabeth McCarthy		14. NAME OF HUSBAND OR WIFE Gertrude Keller	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME Chas. Burke-East St. Louis, Ill.		ADDRESS	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cancer of Pancreas							
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	ANTECEDENT CAUSES						
	DUE TO (b) unk-general						
	DUE TO (c) Abdominal Circumcision						
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 Cancer of Pancreas					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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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)	
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? HIT			

22. I hereby certify that I attended the deceased from 11-20-1948 to 2-17-1949, that I last saw the deceased alive on 2-14, 1949, and that death occurred at 8 m., from the causes and on the date stated above.

23a. SIGNATURE J.W. Thompson-M.D. (Degree of title)		23b. ADDRESS 4952 Maryland		23c. DATE SIGNED 2/18/49	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 2-18-49	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) East St. Louis, Ill.		
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DATE RECEIVED BY REG. FEB 18 1949	REGISTRAR'S SIGNATURE J. B. Laster		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Chas. M. Burke - East St. Louis, Ill.		
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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MWB

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.

Student
Student Embalmer

Signed Chas M Burke

Licensed Embalmer No. 2421

P. O. Address East Spornin

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.