

FILED AUG 13 1949

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

24821

6195

1(%)

REG. DIST. NO.

318

PRIMARY REG. DIST. NO.

1003

State File No.

6764

Registrar's No.

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY 011	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1.		d. STREET ADDRESS (If rural, give location) 1421 Hogan	
3. NAME OF DECEASED (Type or Print) a. (First) WILLIAM b. (Middle) GLEESON c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) July 28th, 1949
5. SEX Male <input checked="" type="checkbox"/>	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6/17/76
9. AGE (In years last birthday) 73		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Ireland 4
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME Conn Gleeson	
13b. MOTHER'S MAIDEN NAME Margaret Unknown		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT'S SIGNATURE OR NAME Margaret Kelly		ADDRESS 2331 Mullerphy	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Pneumonia</i> INTERVAL BETWEEN ONSET AND DEATH *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <i>Malnutrition & Dehydration</i> <i>Arterio Sclerotic Heart Disease</i> 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	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) P.S.A.	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? H2O		22. I hereby certify that I attended the deceased from 7/26/49 to 7/28/49, 1949, that I last saw the deceased alive on 7/28/49, 1949, and that death occurred at 11:00 PM, from the causes and on the date stated above.	
23a. SIGNATURE Carou Heidin M.D.		23b. ADDRESS 1515 Lafayette Ave.,	
23c. DATE SIGNED 7/29/49		24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
24b. DATE 8-4-49		24c. NAME OF CEMETERY OR CREMATORY CALVARY	
24d. LOCATION (City, town, or county) (State) ST LOUIS MO		25. FUNERAL DIRECTOR'S SIGNATURE Boullay-Kelly	
25. ADDRESS 4386 Fiddell		DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE AUG 4 1949 J. B. Lasater	

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

James A. Lammers

Licensed Embalmer No. *4192*

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.