

FILED AUG 27 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH 1003

28376

State File No. 7158

318

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____		
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY _____				
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>		17		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>DePaul Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>15 - 4132 Minnesota Ave.</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>MARY</u>		b. (Middle) _____		c. (Last) <u>MULLALLY</u>		4. DATE OF DEATH (Month) <u>Aug.</u> (Day) <u>15</u> (Year) <u>1949</u>		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>		8. DATE OF BIRTH <u>Nov. 20, 1901</u>		
9. AGE (In years last birthday) <u>47</u>		IF UNDER 1 YEAR Months <u>8</u> Days <u>25</u>		IF UNDER 18 HRS. Hours _____ Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>			10b. KIND OF BUSINESS OR INDUSTRY _____			11. BIRTHPLACE (State or foreign country) <u>Farmington, Mo.</u>		
12. CITIZEN OF WHAT COUNTRY? _____			13a. FATHER'S NAME <u>John Burks</u>		13b. MOTHER'S MAIDEN NAME <u>Ellen Lange</u>		14. NAME OF HUSBAND OR WIFE <u>Late Patrick Mullally</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>John W. Mullally</u>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma ovaries Bil.</u> INTERVAL BETWEEN ONSET AND DEATH _____ ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>metastasis to liver</u>				
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>Cu ovaries</u>				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) <u>Mo.</u>				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>175X</u>				
22. I hereby certify that I attended the deceased from <u>5/30, 1949</u> , to <u>8/15, 1949</u> , that I last saw the deceased alive on <u>8/14, 1949</u> , and that death occurred at <u>6:40A m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE <u>L. Hoyle M.D.</u> (Degree or title)				23b. ADDRESS <u>589 9. Delmar</u>		23c. DATE SIGNED <u>8/16/49</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Aug. 18, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Jefferson Barracks, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>AUG 16 1949</u>		REGISTRAR'S SIGNATURE <u>J. B. Lasater</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Kriegshauser</u> ADDRESS <u>4228 S. Kingshighway Bl.</u>				

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

589948

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 *Edwin M. Bernatt*

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.