

FILED JAN 10 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **43239**
04839
Registrar's No.

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give town) Rural Wellston		c. CITY (If outside corporate limits, write RURAL and give township) Rural Wellston 96	
c. LENGTH OF STAY (in this place) 30 yrs. 4 mos.		d. STREET ADDRESS (If rural, give location) 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Vincent's Sanitarium			
3. NAME OF DECEASED (Type or Print) a. (First) Cecilia		b. (Middle) _____ c. (Last) Gallagher	
4. DATE OF DEATH (Month) (Day) (Year) Dec. 30 1949		5. SEX Female 6. COLOR OR RACE White	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow		8. DATE OF BIRTH Apr. 5, 1883	
9. AGE (In years last birthday) 66		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME Michael Foster		13b. MOTHER'S MAIDEN NAME Mathilda Amend	
14. NAME OF HUSBAND OR WIFE James Gallagher		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME Sister Margaret Mary Wellston Mo. ADDRESS _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* Dementia Paralytica, tabetic form			
INTERVAL BETWEEN ONSET AND DEATH 30 years			
*This does not mean the mode of dying, such as heart failure, asthenia, 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.			
DUE TO (b) _____			
DUE TO (c) _____			
II. OTHER SIGNIFICANT CONDITIONS Psychosis & Syphilis of Central Nervous System			
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 checked="" type="checkbox"/> NO <input type="checkbox"/>		025X	
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? _____	
22. I hereby certify that I attended the deceased from Jan. 2, 1948 , to Dec. 30, 1949 , that I last saw the deceased alive on Dec. 30, 1949 , and that death occurred at 4:20 p. m. , from the causes and on the date stated above.			
23a. SIGNATURE J.R. Bawert M.D. (Degree or title)		23b. ADDRESS 7511th Delmar Blvd.	
23c. DATE SIGNED 12-30-49		24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
24b. DATE 1-3-50		24c. NAME OF CEMETERY OR CREMATORY CALVARY	
24d. LOCATION (City, town, or county) ST. LOUIS (State) Mo		25. FUNERAL DIRECTOR'S SIGNATURE Cullen & Kelly ADDRESS 7267 NATURAL BRIDGE	
DATE REC'D BY LOCAL REG. 1-2-50		REGISTRAR'S SIGNATURE Herbert B. Donke M.D.	

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

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 James A. Lammons

Signed.....
Student Embalmer

Licensed Embalmer No. 4142

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.