

FILED MAY 4 1951

STANDARD CERTIFICATE OF DEATH

318

1003

14011
State File No. 3277
Registrar's No.

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo.		b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis		c. LENGTH OF STAY (In this place) 7		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis 2079	
d. FULL NAME OF HOSPITAL OR INSTITUTION DePaul Hospital		d. STREET ADDRESS (If rural, give location) 4929 Hooke Ave.			
3. NAME OF DECEASED (Type or Print) a. (First) Mary		b. (Middle) Elizabeth		c. (Last) Duggan	
4. DATE OF DEATH (Month) (Day) (Year) April 5 1951		5. SEX Female		6. COLOR OR RACE White	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Never married		8. DATE OF BIRTH July 23 1886		9. AGE (In years last birthday) 64	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Clothing		11. BIRTHPLACE (State or foreign country) St. Louis Mo.	
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME Michael Duggan		13b. MOTHER'S MAIDEN NAME Johanna Maher	
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)		16. SOCIAL SECURITY NO. 489-05-2991	
17. INFORMANT'S SIGNATURE OR NAME William Duggan		ADDRESS 4929 Hooke Ave.			
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, asthma, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) MEDICAL CERTIFICATION <i>Fibrillary Astrocytoma</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 yr</i>	
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 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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <i>143X</i>	
22. I hereby certify that I attended the deceased from <i>January 1951</i> to <i>April 5, 1951</i> , that I last saw the deceased alive on <i>April 5, 1951</i> , and that death occurred at <i>2:30 p.m.</i> , from the causes and on the date stated above.					
23a. SIGNATURE <i>Raymond A. Meyers</i>		(Design or title) Mo.		23b. ADDRESS <i>539 N. Grand Blvd</i>	
23c. DATE SIGNED <i>4-6-51</i>		24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24b. DATE <i>4/9/51</i>	
24c. NAME OF CEMETERY OR CREMATORY <i>Calvary</i>		24d. LOCATION (City, town, or county) (State) <i>St. Louis Mo.</i>			
DATE RECD BY LOCAL REG. <i>APR 7 1951</i>		REGISTRAR'S SIGNATURE <i>J. B. Lassiter</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Sullivan Funeral Dire</i>	
				ADDRESS <i>2849 N. Euclid</i>	

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 _____

working under my personal supervision.

Signed.....
Student Embalmer

Signed *Robert H. Linkman*
Student Embalmer No.
Licensed Embalmer No. 3583

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.