

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28154
7049

State File No.

FILED AUG 25 1951

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's 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, Missouri		c. CITY (If outside corporate limits, write RURAL and give township) St Louis MO	
c. LENGTH OF STAY (in this place) 1 Mos. 18 Day		d. STREET ADDRESS (If rural, give location) 4932 Stralbins	
d. FULL NAME OF HOSPITAL OR INSTITUTION City Infirmary Hospital		e. CITY OR TOWN 2079	

3. NAME OF DECEASED (Type or Print)	a. (First) Joseph	b. (Middle) P.	c. (Last) Cullinane	4. DATE OF DEATH (Month) (Day) (Year) Aug. 6, 1951
-------------------------------------	--------------------------	-----------------------	----------------------------	--

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH Aug 5, 1873	9. AGE (In years last birthday) 78	10. IF UNDER 1 YEAR Months Days	10. IF UNDER 1 YEAR Hours Min.
--------------------	-------------------------------	--	-------------------------------------	---	---------------------------------	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired laborer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTH PLACE (State or foreign country) St Louis MO	12. CITIZEN OF WHAT COUNTRY?
--	-----------------------------------	---	------------------------------

13a. FATHER'S NAME Wm Cullinane	13b. MOTHER'S MAIDEN NAME Shanna Briens	14. NAME OF HUSBAND OR WIFE None
--	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Ms John Ross	ADDRESS 4932 Stralbins
--	-------------------------------------	---	-------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 15 yrs
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) Cerebral Arteriosclerosis		
	ANTECEDENT CAUSES		
	DUE TO (b) _____		

DUE TO (c) _____		II. OTHER SIGNIFICANT CONDITIONS Chronic bronchitis	15 yrs +
------------------	--	--	----------

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 334x	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) (Min)	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 June 19, 1951, to Aug. 6, 1951, that I last saw the deceased alive on August 6, 1951, and that death occurred at 8:15 P.M., from the causes and on the date stated above.

23a. SIGNATURE William M.weeney MD (Degree or title)	23b. ADDRESS 5600 Arsenal Street	23c. DATE SIGNED Aug. 7, '51.
---	---	--------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 8/8/51	24c. NAME OF CEMETERY OR CREMATORY Calvary	24d. LOCATION (City, town, or county) (State) St Louis MO
---	-------------------------	---	--

DATE REC'D BY LOCAL REG. AUG 7 1951	REGISTRAR'S SIGNATURE J B Foster	25. FUNERAL DIRECTOR'S SIGNATURE SULLIVAN FUN DIR 2849 Euclid	ADDRESS
--	---	--	---------

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

No. 300
10-48

Handwritten notes, possibly a date and name, written upside down.

Handwritten notes, possibly a date and name, written upside down.

Large handwritten notes, possibly a name and address, written upside down.

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 *Eustace J. Dutelle*

Licensed Embalmer No. *4329*

P. O. Address *St Louis Mo*

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.

Handwritten notes at the bottom of the page, including a date and name, possibly a signature.