

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED AUG 23 1951

BIRTH NO. _____		REG. DIST. NO. 317		PRIMARY REG. DIST. NO. 3065		Registrar's No. 2891	
1. PLACE OF DEATH a. COUNTY ST. LOUIS				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO b. COUNTY ST. LOUIS			
b. CITY (If outside corporate limits, write RURAL and give township) GLENDALE		c. LENGTH OF STAY (In this place) 28 DAYS		c. CITY (If outside corporate limits, write RURAL and give township) 18 OR TOWN NORMANDY, MO 4181			
d. FULL NAME OF HOSPITAL OR INSTITUTION OAKLAND PARK HOSPITAL				d. STREET ADDRESS (If rural, give location) 7626 NATURAL BRIDGE RD.			
3. NAME OF DECEASED a. (First) Mary		b. (Middle)		c. (Last) Cullen		4. DATE OF DEATH (Month) (Day) (Year) Aug. 13, 1951	
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE		8. DATE OF BIRTH MCH. 5-1861	
9. AGE (In years last birthday) 90 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ILLINOIS	
12. CITIZEN OF WHAT COUNTRY? U.S.		13a. FATHER'S NAME JAMES CULLEN		13b. MOTHER'S MAIDEN NAME MARY BULGER		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS Clem F. Storchman - 411 N. 7th St.			
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 4222 II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cerebral arterio-sclerosis				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) 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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) _____				23b. ADDRESS 325 Feira Blvd St.		23c. DATE SIGNED Aug. 13/51	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE AUG. 14-1951		24c. NAME OF CEMETERY OR CREMATORY CALVARY CEM.		24d. LOCATION (City, town, or county) (State) ST. LOUIS, MO	
DATE REC'D BY LOCAL REG. 8-13-51		REGISTRAR'S SIGNATURE Robert P. Donke		FUNERAL DIRECTOR'S SIGNATURE W. MULLEN UND CO.		ADDRESS 5165 DELMAR BL	

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

JAN 9 1958

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.

Student Embalmer No.

Signed

Ronald O. Johnke

Signed.....

Student Embalmer

Licensed Embalmer No. *3917*

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.