No. 300
10.48

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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14083

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 2485

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

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Faith Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Mo.
b. COUNTY: St. Louis
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Greendale 4181
d. STREET ADDRESS (If rural, give location): 2220 Atwater Dr.

3. NAME OF DECEASED (Type or Print): a. (First) Gertrude b. (Middle) Agnes c. (Last) Bresnahan

4. DATE OF DEATH (Month) (Day) (Year): Mar. 14 - 52

5. SEX: F
6. COLOR OR RACE: Wh
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH: Jan 19-1904
9. AGE (In years last birthday): 48 IF UNDER 1 YEAR Months: 1 Days: 25 IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nursery School Teacher
10b. KIND OF BUSINESS OR INDUSTRY: St. Marys School
11. BIRTHPLACE (State or foreign country): St. Louis Mo.
12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME: Thomas M. Monks
13b. MOTHER'S MAIDEN NAME: Nellie O'Connell
14. NAME OF HUSBAND OR WIFE: John P.

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.
17. INFORMANT'S SIGNATURE OR NAME: Donald Bresnahan ADDRESS: 2220 Atwater Dr.

MEDICAL CERTIFICATION

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.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 10 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) None
DUE TO (c) None

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION: ✓
19b. MAJOR FINDINGS OF OPERATION: ✓
20. AUTOPSY? YES ☐ NO ☒

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? ✓ 416 X

22. *I hereby certify that I attended the deceased from* 3/4, 1952, *to* 3/14, 1952, *that I last saw the deceased alive on* 3/13, 1952, *and that death occurred at* 6 A. m., *from the causes and on the date stated above.*

23a. SIGNATURE: Jim O'Reilly (Degree or title) M.D.
23b. ADDRESS: 730 Hodiamont
23c. DATE SIGNED: 3/14/52

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 3-17-52
24c. NAME OF CEMETERY OR CREMATORY: Calvary Cem.
24d. LOCATION (City, town, or county) (State): St. Louis Mo.

DATE REC'D BY LOCAL REG. MAR 15 1952
REGISTRAR'S SIGNATURE: J. Earl Smith M.D.
25. FUNERAL DIRECTOR'S SIGNATURE: Chas. F. Smart ADDRESS: 1225 Union
(Licensed Embalmer's Statement on Reverse Side)

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 Clement McNeary

Licensed Embalmer No. 3732

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.