

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **3921**  
Registrar's No. **0513**

FILED JAN 28 1953

318 1003

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		2079	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>De Paul Hospital</b>				d. STREET ADDRESS (If rural, give location) <b>7 4553 Durant Ave.,</b> 0			
3. NAME OF DECEASED (Type or Print) a. (First) <b>John</b> b. (Middle) <b>M.</b> c. (Last) <b>Whalen</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Jan. 15, 1953</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Never Married</b>	8. DATE OF BIRTH <b>Nov. 20, 1907</b>	9. AGE (In years last birthday) <b>45</b>	IF UNDER 1 YEAR Months Days	IF UNDER 2 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U</b>
13a. FATHER'S NAME <b>John M. Whalen</b>		13b. MOTHER'S MAIDEN NAME <b>Nellie Fitzgerald</b>		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) <b>Yes W.W.#2</b>		16. SOCIAL SECURITY NO. <b>337-03-8236</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Annabella Turpel, 4553 Durant</b>			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Arterio-Sclerotic Heart Disease</b> ANTECEDENT CAUSES <b>Arterio Sclerosis</b> 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 <b>Chronic Glomerulonephritis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 years</b> <b>5 years</b> <b>8 years</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? <b>Yes</b> <input checked="" type="checkbox"/> <b>No</b> <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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>4200</b>			
22. I hereby certify that I attended the deceased from <b>Dec 21st 1952 to Jan 15, 1953</b> that I last saw the deceased alive on <b>Jan 15th, 1953</b> and that death occurred at <b>6 P</b> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>J. J. Gallagher M.D.</b>				23b. ADDRESS <b>3903 Olive</b>		23c. DATE SIGNED <b>Jan 16 1953</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>1-19-1953</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>		
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <b>JAN 16 1953</b> <b>J. C. Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Cullinane Bros</b>		ADDRESS <b>3320 N. Kingshighway</b>			

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.

Student Embalmer No. ....

Signed.....

*Fred Frick*

Signed.....

Student Embalmer

Licensed Embalmer No. 3186

P. O. Address St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.