

FILED FEB 27 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6315

State File No.

318

1003

1276

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 Missouri b. COUNTY St. Louis				
b. CITY (If outside corporate limits, write RURAL and give town or township) ST. LOUIS		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN Clayton 4462		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION Bernard Nursing Home				e. STREET ADDRESS (If rural, give location) # 30 Wydown Terrace				
3. NAME OF DECEASED (Type or Print) a. (First) CATHRYN b. (Middle) MAY c. (Last) COSGROVE.			4. DATE OF DEATH (Month) (Day) (Year) Feb. 4, 1956					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH May 22, 1903		
9. AGE (In years last birthday) 52		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 18 HRS. Hours _____ Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife			10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME James E. Barry.			13b. MOTHER'S MAIDEN NAME Rose Maynard.		14. NAME OF HUSBAND OR WIFE Joseph R. Cosgrave.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Joseph R. Cosgrave; #30 Wydown Terrace.				
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.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Subarachnoid hemorrhage				INTERVAL BETWEEN ONSET AND DEATH 2 1/2 mo.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				DUE TO (b) Berry aneurysm at Cerebrum				?
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"/>		330x		
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? _____				
22. I hereby certify that I attended the deceased from Nov 21, 1955 to Feb 4, 1956, that I last saw the deceased alive on Feb 4, 1956 and that death occurred at 7 P. m., from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <i>Harriet M Grant MD</i>				23b. ADDRESS 114 N Taylor Ave		23c. DATE SIGNED Feb 6 '56		
24a. BURIAL, CREMATION, REMOVAL (Specify) Interment		24b. DATE 2-7-1956		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Missouri		
DATE REC'D BY LOCAL REG. FEB 6 1956		REGISTRAR'S SIGNATURE <i>J. C. Smith MD</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C. R. Lupton & Sons; 7233 Delmar Blvd.				

(Licensed Embalmer's Statement on Reverse Side)

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

(CROSSCHECK)

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.....
Signature of Student Embalmer

Signed *Clarence H. Murr*.....

Licensed Embalmer No. *40*.....

P. O. Address *S. T. Pe*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.