

18051-56

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14481

State File No. _____

FILED APR 30 1956

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1003

37276

1. PLACE OF DEATH a. COUNTY St. Louis		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 township) St. Louis		c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION St Johns		e. STREET ADDRESS (If rural, give location) 10 4312 penrose 2109d	
3. NAME OF DECEASED (Type or Print) a. (First) Patricia b. (Middle) Ann c. (Last) Brennan		4. DATE OF DEATH (Month) (Day) (Year) 4/14/56	
5. SEX Fe	6. COLOR OR RACE Wh	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH 3/21/56
9. AGE (In years last birthday) 24		IF UNDER 1 YEAR Months 3 Days 24 Hours 15 Min.	IF UNDER 24 HRS. Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) no		10b. KIND OF BUSINESS OR INDUSTRY no	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME James Brennan	
13b. MOTHER'S MAIDEN NAME Mary Finazzo		14. NAME OF HUSBAND OR WIFE No	
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. No	17. INFORMANT'S SIGNATURE OR NAME ADDRESS James Brennan 4312 Penrose
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) Gangrene of intestine ANTECEDENT CAUSES Malnutrition of bowel 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.	
19a. DATE OF OPERATION 3-29-56		19b. MAJOR FINDINGS OF OPERATION Malnutrition of intestine, Gangrene	
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) 756-2	
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? 756-2		22. I hereby certify that I attended the deceased from 3-27 , 19 56 , to 4-14 , 19 56 , that I last saw the deceased alive on 4-14 , 19 56 , and that death occurred at 9:25 a.m. , from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) James H. Smith M.D.		23b. ADDRESS 634 N. Grand	
23c. DATE SIGNED 4-16-56		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE 4/16/56		24c. NAME OF CEMETERY OR CREMATORY Calvary	
24d. LOCATION (City, town, or county) (State) St. Louis, Mo		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Miceli 1150 N Kingshiway	
DATE REC'D BY LOCAL REG. APR 16 1956		REGISTRAR'S SIGNATURE J. Carl Smith M.D. mjs (Licensed Embalmer's Statement on Reverse Side)	

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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

J. W. Binkley

Licensed Embalmer No. *365*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.