

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **22404**

FILED JUN 29 1956

BIRTH NO. _____		REG. DIST. NO. 317		PRIMARY REG. DIST. NO. 500		Registrar's No. 1405	
1. PLACE OF DEATH a. COUNTY St. Louis				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Luxemburg		c. LENGTH OF STAY (in this place) 6 Mon.		c. CITY OR TOWN St. Louis		d. 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 Mt. St. Rose Hosp.				e. STREET ADDRESS (If rural, give location) 3541 Park Ave. 2189			
3. NAME OF DECEASED (Type or Print) a. (First) Mary Ann		b. (Middle) _____		c. (Last) Gilbride		4. DATE OF DEATH (Month) (Day) (Year) 6/6/56	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH 5/18/1887	
9. AGE (In years last birthday) 69 yrs		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 11 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (City and State or Foreign Country) Moro, Ill.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME George Luman		13b. MOTHER'S MAIDEN NAME Adeline Green		14. NAME OF HUSBAND OR WIFE James H. Gilbride			
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 Adeline Helmantoler 419 Dulaney, Wood River			
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.		<p align="center">MEDICAL CERTIFICATION</p> <p align="center">I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Tuberculosis</p> <p align="center">ANTECEDENT CAUSES</p> <p>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</p> <p align="center">DUE TO (b) _____</p> <p align="center">DUE TO (c) _____</p> <p>II. OTHER SIGNIFICANT CONDITIONS Arteriosclerotic Cardiovascular Disease</p> <p>Conditions contributing to the death but not related to the disease or condition causing death.</p>					
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" 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) 002 X			
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 15 Dec, 1955 , to 6 June, 1956 , that I last saw the deceased alive on 4 June, 1956 , and that death occurred at 2:45 p.m. , from the causes and on the date stated above.							
23a. SIGNATURE John J. McCann		(Degree or title) MD		23b. ADDRESS 16 Hampton Village Plaza		23c. DATE SIGNED 6 June 56	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 6/9/56		24c. NAME OF CEMETERY OR CREMATORY Upper Alton		24d. LOCATION (City, town, or county) (State) Alton, Illinois	
DATE REC'D BY LOCAL REG. 6-8-56		REGISTRAR'S SIGNATURE Herbert B. Dombrowski		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS E.J. Schnur 3125 Lafayette Ave. St. L. Mo.			

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 *Thomas R. Jenovik*

Licensed Embalmer No. *3793*

P. O. Address *3125 Lafayette*

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.