

Health,
Welfare
Public
Service

3300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED OCT 10 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33138

STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. 6075 Registrar's No. 303

1. PLACE OF DEATH a. COUNTY <u>St. Francois</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Francois Twp.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Normandy</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital #4</u>		Length of stay in 1b <u>16y, 10m, 18d</u>		d. STREET ADDRESS (If outside, give location) <u>711 North Hill Dr.</u>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u></u> Last <u>KOHLER</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>10</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 21, 1896</u>		9. AGE (In years last birthday) <u>61</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Michael Gilfoyle</u>				14. MOTHER'S MAIDEN NAME <u>Nellie Dugan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Records, State Hospital #4, Farmington, Mo.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial pneumonia</u> ----- DUE TO (b) <u>Cerebral thrombosis</u> ----- DUE TO (c) <u>332X</u> ----- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Dementia Praecox Psychosis</u> ----- <u>Abt. 21 years.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hours.</u> <u>24 hours.</u>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour <u></u> Month <u></u> Day <u></u> Year <u></u> a. m. <u></u> p. m. <u></u>							
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>Sept. 8, 1957</u> to <u>Sept. 10, 1957</u> and last saw her <u>alive</u> on <u>Sept. 10, 1957</u> Death occurred at <u>12:45 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>John A. Brennan MD</u>				22b. ADDRESS <u>State Hospital No. 4, Farmington, Mo.</u>		22c. DATE SIGNED <u>9-10-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Sept. 13, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SS. Peter & Paul Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>7030 Gravois, St. Louis, Mo.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Gabken Benz, 2842 Meramec, St. Louis, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>Sept. 10, 1957</u>		26. REGISTRAR'S SIGNATURE <u>Esther Rudloff</u>	

(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
Signature of Student Embalmer

Signed *C. Cozear*

Licensed Embalmer No. *46*

P. O. Address *Farmington*

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.