

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010926
STATE FILE NUMBER
2354

FILED MAR 30 1959

Registration District No. _____ Primary Registration District No. _____ Registrar 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, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Lemay 4870 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Anthony Hospital		Length of stay in lb 4 Days	d. STREET ADDRESS (If outside, give location) 117 Mann Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last Mildred Josephine Galeski			4. DATE OF DEATH Month Day Year March 5, 1959		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 11, 1915	9. AGE (In years last birthday) 43	IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundry Worker	10b. KIND OF BUSINESS OR INDUSTRY Excelsior Laundry Co. St. Louis, Missouri	11. BIRTHPLACE (City and state or country) 0	12. CITIZEN OF WHAT COUNTRY? U S A
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13a. FATHER'S NAME Henry Heinold	13b. MOTHER'S MAIDEN NAME Ethel McMillan	14. NAME OF HUSBAND OR WIFE Harold
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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. 491-18-3024	17. INFORMANT Joseph H. Galeski 117 Mann St. Lemay 25, Mo.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage from vagina Primary carcinoma of cervix Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) with metastases to abdominal viscera DUE TO (c) 6 mo		INTERVAL BETWEEN ONSET AND DEATH 5 days 1 yr 6 mo
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 171X		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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 Month, Day, Year a.m. p.m.	

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 3/1/58 6:50 PM to 3/5/59 3/5/59	COUNTY	STATE
21. I attended the deceased from 3/1/58 and last saw her 3/5/59 alive on 3/5/59 . Death occurred at: 6:50 PM on the date stated above; and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE George A. O'Sullivan, M.D.	22b. ADDRESS 7629 Ivory Ave.	22c. DATE SIGNED 3-6-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE March 9, 1959	23c. NAME OF CEMETERY OR CREMATORY Mount Olive Cemetery	23d. LOCATION (City, town, or county) 3901 Mt. Olive Rd. Lemay, Mo.
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24. FUNERAL DIRECTOR C. Homeister Mortuaries 7817 S. Broadway	25. DATE RECD. BY LOCAL REG. MAR 6 '59	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Linus C. Hoffmeister*

Licensed Embalmer No. *3871*

P. O. Address *7814 S. Brown*

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.