

U.S. DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-038408

FILED VS NOV 16 1959

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 548 Registrar's No. 2953

ENDED

12/9/59

Hardware

Electrical contractor

10b

BY AFFIDAVIT OF Funeral Director

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</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>Webster Groves</u> | | Length of stay in 1b <u>8 months</u> | | c. CITY OR TOWN <u>Webster Groves</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>Bethesda Gen. Hospital</u> | | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>1001 Big Bend Rd.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Lydia</u> Middle <u>V.</u> Last <u>Bulger</u> | | | | 4. DATE OF DEATH Month <u>November</u> Day <u>6</u> Year <u>1959</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>Caucasian</u> | | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH <u>3/27/1876</u> | |
| 9. AGE (last birthday) <u>83</u> | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Proprietor</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Hardware</u> | |
| 10c. FATHER'S NAME <u>Chief clerk</u> | | 13b. MOTHER'S MAIDEN NAME <u>Rebecca Beggs</u> | | 11. BIRTHPLACE (City and state or country) <u>New Orleans, La.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</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>496-36-7416</u> | | 17. INFORMANT Address <u>Atlanta, Ga.</u> <u>Mrs. Fred W. Slygh, 970 Davis Dr.</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>Carcinoma Rt Breast</u> DUE TO (b) <u>with general Metastases</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 <u> </u> a.m. <u> </u> p.m. <u> </u> Month, Day, Year <u> </u> <u> </u> <u> </u> | | 20d. INJURY OCCURRED WHILE AT WORK <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>July 15 1959</u> to <u>Nov. 6 1959</u> and last saw her alive on <u>Nov. 5 1959</u> . Death occurred at <u>8:00 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u> </u> | | | | 22b. ADDRESS <u>Webster Groves Mo</u> | | 22c. DATE SIGNED <u>11-6-59</u> | |
| 23a. FUNERAL CREMATION <u>Funeral</u> | | 23b. DATE <u>11/7/1959</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Missouri</u> | |
| 24. FUNERAL DIRECTOR <u>Hollmeister Colonial Mortuary</u> <u>6464 Chippewa St., St. Louis, Mo.</u> | | | | 25. DATE RECD. BY LOCAL REG. <u>11-6-59</u> | | 26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u> | |

VS DEC 23 1958

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 Bill C. Branson

Licensed Embalmer No. 4767

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.