

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS FEB 2 1961

-61-001935
STATE FILE NUMBER

AMENDED

Registration District No. 162 Primary Registration District No. 5594 Registrar's No. 86

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

AFFIDAVIT OF

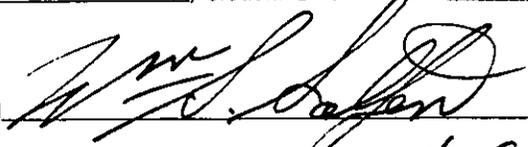
1. PLACE OF DEATH a. COUNTY Jefferson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Rural-Meramec		Length of stay in 1b 2-years		c. CITY OR TOWN St Louis (24)		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St Josephs Hill Infirmary			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS 1440 Spodee Rd (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Dr John Middle Francis Last Gallagher				4. DATE OF DEATH Month 1 Day 14 Year 61									
5. SEX Male		6. COLOR OR RACE White		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 12-26-1884		9. AGE (last birthday) 76		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Physician		11. BIRTHPLACE (City and state or country) O'Neill Nebraska		12. CITIZEN OF WHAT COUNTRY U.S.A.					
13a. FATHER'S NAME Michael Gallagher				13b. MOTHER'S MAIDEN NAME Bridget Erwin				14. NAME OF HUSBAND OR WIFE Mary					
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 Address Mary Gallagher 1440 Spodee Road							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) DUE TO (b) Multiple cerebral thromboses DUE TO (c) Cerebral arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 6 years													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arteriosclerotic heart disease with complete A-V block								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
19. WAS AUTOPSY PERFORMED? YES <input checked="" 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 a.m. p.m.		Month, Day, Year											
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 February 18, 1955 , to January 14, 1961 and last saw ^{her} him alive on January 13, 1961 Death occurred at: 943 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) John T. Lewiston, M.D.						22b. ADDRESS 634 71 Grand Blvd.			22c. DATE SIGNED Jan. 14, 1961				
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE 1-17-1961		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or county) (State) St Louis Mo							
24. FUNERAL DIRECTOR ADDRESS Arthur J. Nowell, 3840 Lindell Blvd				25. DATE RECD. BY LOCAL REG. 1-14-61		26. REGISTRAR'S SIGNATURE Robert E. Bauer							

MS FEB 2 1961

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  _____

Licensed Embalmer No. 4699

P. O. Address 3840 Dundas

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.