

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REC'D SEP 12 1938

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

27100
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No. **791**
(b) Township..... Primary Registration District No. **1003**
(c) City **St. Louis Mo** (d) Street No. **Barnes Hospital** Registered No. **7114**
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **Mary Ann Gibbons 152**

(a) Residence, No. **1107 Etzel Tr** St. **5**
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Widowed**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Thomas**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **July 22 1878**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ? hrs. or ? min.
60 - 18

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Housewife**
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) **7-20-38** 11. Total time (years) spent in this occupation **1**

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Ireland**

FATHER
13. NAME **Peter Cullinane**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Ireland**

MOTHER
15. MAIDEN NAME **Rose McDermott**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Ireland**

17. INFORMANT (ADDRESS) **John Galloway 1107 Etzel Avenue**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Calvary** DATE **8-12-38**

19. FUNERAL DIRECTOR (NAME) (ADDRESS) **Oscar J. Hoffmeister 406 Chippewa St**

20. FILED **J. J. Brudick Local Registrar**

AUG 11 1938

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **8-10-1938**

22. I HEREBY CERTIFY, That I attended deceased from **7-27-1938** to **8-10-1938**

I last saw h. or alive on **8-10-1938** Death is said to have occurred on the date stated above, at **12:30 a.m.**

The principal cause of death and related causes of importance were as follows:

Thyroid Crisis (Date of onset **8-8-38**)

Other contributory causes of importance:
Thyrototoxicosis **March '38**
Thyrototoxic Heart Disease **April '38**

Name of operation..... Date of.....
What test confirmed diagnosis?..... Was there an autopsy? **Yes**

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide?..... Date of injury....., 19.....
Where did injury occur?..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? **no**

If so, specify (Signed) **F. R. Bradley**, M. D.
(Address) **BARNES HOSPITAL**

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

Registered Apprentice No....., working under my personal supervision.

Signed.....

Edwin H. Leubinger

Licensed Embalmer No. *4016*

P. O. Address. *4016 Chippewa St*

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 this body is not embalmed, above space should be left blank.