

Registration District No. **791** Primary Registration District No. **1004**

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
5039 TERRY AVE
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME DANIEL M. GLEASON
8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced 1
6. (b) Name of husband or wife JULIA GLEASON 6. (c) Age of husband or wife if alive 56 years
7. Birth date of deceased 7-14-1879
(Month), (Day), (Year)

8. AGE: Years 61 Months 9 Days 7 If less than one day _____ hr. _____ min.

9. Birthplace 4 IRELAND
(City, town, or county) (State or foreign country)

10. Usual occupation INSURANCE BROKER

11. Industry or business _____
12. Name MAURICE GLEASON
13. Birthplace 4 IRELAND
(City, town, or county) (State or foreign country)
14. Maiden name ELIZABETH SYNGE
15. Birthplace 4 IRELAND
(City, town, or county) (State or foreign country)

16. (a) Informant MRS. JULIA GLEASON
(b) Address 5039 TERRY AVE

17. (a) BURIAL (b) Date thereof 5-23-41
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation CALVARY CEMETERY

18. (a) Signature of funeral director SULLIVAN BROS
(b) Address 2849 N. EUGENIA AVE

19. (a) MAY 21 1941 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town ST. LOUIS 16 17
(If outside city or town limits, write "RURAL")
(d) Street No. 5039 TERRY AVE 9
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 21st
year 1941 hour 4 minute 30 P.M.
21. I hereby certify that I attended the deceased from 3/6/40
_____ 19 _____ to 5/20/41, 1941;
that I last saw him alive on 5/20/41, 19 _____
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis Duration 1yr

Due to Atherosclerosis

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operation [Signature] Of autopsy [Signature]
PHYSICIAN _____
Underlines the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (f) Means of injury _____

23. Signature James A. Sullivan (M. D. or other) _____
Address 2849 N. Union St Date signed 5/21/41

00
17
9
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DR SULLIVAN
78642 N. UNIONS

MAR 31 1944

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 Albert Mayfield

Licensed Embalmer No. 3077

P. O. Address St. Louis Mo

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.