

FILED JUL 23 1945

Registration District No. 377

Primary Registration District No. 30696076

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
 (a) County St. Louis
 (b) City or town Richmond Heights
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: St. Mary's Hospital
 (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 Sandra Louise Gallagher
 3. (b) If veteran, name war No
 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased: June 21st, 1945
 (Month) (Day) (Year)

| 8. AGE: | Years | Months | Days | If less than one day |
|---------|-------|--------|------|----------------------|
| | 0 | 0 | 25 | hr. _____ min. |

9. Birthplace St. Louis, Missouri
 (City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business _____

MOTHER FATHER

12. Name Thomas J. Gallagher
 13. Birthplace Unk Missouri
 (City, town, or county) (State or foreign country)
 14. Maiden name Louise Hanson
 15. Birthplace Unk Arkansas
 (City, town, or county) (State or foreign country)

16. (a) Informant Thomas J. Gallagher
 (b) Address 2827 Hanley Rd

17. (a) Burial (b) Date thereof 7-18-45
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Jos. W. Clark
 (b) Address 1125 Hodiamont Ave

19. (a) 7-18-1945 (b) E. J. DeSarran
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County St. Louis
 (c) City or town Overland
 (If outside city or town limits, write "RURAL")
 (d) Street No. 2827 Hanley Rd.
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 16th,
 year 1945 hour 5.30 minute A M.
 21. I hereby certify that I attended the deceased from 6-21-45 to 7-16-45,
 that I last saw her alive on 7-15-45,
 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary embolism
 Duration 2 1/2 hrs

Due to _____
 Due to 159
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy _____
 PHYSICIAN _____
 Underline 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) (a) Means of injury _____
 23. Signature P. J. DeSarran (M. D. or Gen. Pr.)
 Address 634 N. Grand Date signed 7-16-45

John G. Brown

634 N. Grand

11-2

634 N. Grand

Dr. Patrick H. Davis

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 W. W. Wilkins

Licensed Embalmer No. 3575

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, fact should be so stated above.