

No. 2  
12-45  
17-39  
X47070

DEPARTMENT OF COMMERCE  
BUREAU OF CEMETERIES

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **35142**  
Registrar's No. **8637**

Registration District No. **318** Primary Registration District No. **1003**

1. PLACE OF DEATH:  
(a) County.....  
(b) City or town **St. Louis**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**St. Louis City Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **3 Months**  
(Specify whether  
In this community  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Mo.** (b) County **0-0-0**  
(c) City or town **St. Louis**  
(If outside city or town limits, write "RURAL") **217**  
(d) Street No. **821a North 19th. St**  
(If rural, give location) **90**  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME **John F. Gallagher**  
3. (b) If veteran, name war  
3. (c) Social Security No.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **Oct.** day **7th**  
year **1946** hour **5** minute **41.8** M.  
21. I hereby certify that I attended the deceased from  
19... to 19...  
that I last saw him alive on 19...  
and that death occurred on the date and hour stated above.

4. Sex **M.** 5. Color or race **W.**  
6. (a) Single, widowed, married, divorced **Single**

Immediate cause of death **Lobar pneumonia** Duration  
**fracture of left hip**  
**When he fell to the floor in his room on Aug 4, 1946 about 12:30 P.M.**

6. (b) Name of husband or wife  
6. (c) Age of husband or wife if alive years  
7. Birth date of deceased **June 10th, 1867**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**79 3 27** hr. min.

Due to  
Other conditions (Include pregnancy within 3 months of death)  
Major findings:  
Of operations  
Of autopsy

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

10. Usual occupation **Retired**

11. Industry or business **Majestic Range**

12. Name **John Gallagher**  
13. Birthplace **Ireland**  
(City, town, or county) (State or foreign country)

14. Maiden name **Sally Gallagher**  
15. Birthplace **Ireland**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Julia Kenney Lane**  
(b) Address **1436 Glenlake, Chicago**

17. (a) **Burial** (b) Date thereof **10-9-46**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **Arthur J. Donnelly**  
(b) Address **3840 Rendell Blvd St Louis Mo**

19. (a) **OCT 8 1946** (b) **J. F. Brodeck**  
(Date received local registrar) (Registrar's signature)

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) **Accident**  
(b) Date of occurrence **Aug 4 1946**  
(c) Where did injury occur? **at home**  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
**at home**

While at work? (Specify type of place) Means of injury **at home**

23. Signature **[Signature]** (M. D. or other)  
Address **[Address]** Date signed **10/9/46**

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

MOTHER FATHER

**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 Stanley Marshall

Licensed Embalmer No. 2868

P. O. Address 3840 Lindell

**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.**