

FILED NOV 7 1946

Registration District No. _____

Primary Registration District No. _____

1003

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: Barnes Hospital,
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12 days
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County _____
(c) City or town Galena
(If outside city or town limits, write "RURAL") NR.
(d) Street No. 719 East 5th St.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME ROSE ANNE PICKETT

3. (b) If veteran, name war -- 3. (c) Social Security No. --

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced, widowed
6. (b) Name of husband or wife Mitchell J. Pickett 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Feb. 15 1873
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
73 8 9 _____ hr. _____ min.

9. Birthplace Ireland; Salem, New York
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business _____

12. Name James Murphy
13. Birthplace Ireland
(City, town, or county) (State or foreign country)
14. Maiden name Rose Anne Connelley
15. Birthplace Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant Clark S. Wheeler
(b) Address Indianapolis, Ind.

17. (a) removal (b) Date thereof 10-24-46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Galena, Kansas

18. (a) Signature of funeral director Robert J. Ambruster
(b) Address 6633 Clayton Road

19. (a) OCT 24 1946 (b) J. F. Bredeh
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 24
year 1946 hour 1 minute 50 p.M.

21. I hereby certify that I attended the deceased from Oct. 12 1946 to Oct 24 1946
that I last saw him alive on October 24 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of sigmoid colon with metastases
Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) H6

Major findings: Of operations as above

Of autopsy as above

Duration

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) (e) Means of injury _____

23. Signature J. F. Bredeh (M. D. or _____)
Address Barnes Hospital Date signed 10/24/46

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.....

Licensed Embalmer No.....

P. O. Address.....

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.