

**FILED FEB 10 1947**

**1003**

Registration District No. **318**

Primary Registration District No. \_\_\_\_\_

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

**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:  
5266 MAPLE 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 28 YRS  
years, months or days

**3. (a) PRINT FULL NAME JULIA M. CUNNINGHAM.**

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

4. Sex FEMALE 5. Color or race WHITE  
 6. (a) Single, widowed, married, divorced, WIDOWED  
 6. (b) Name of husband or wife WALTER T. 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased NOV 21 1879  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
67 2 8 hr. \_\_\_\_\_ min.

9. Birthplace ST LOUIS MO  
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSE

11. Industry or business WIFE

12. Name EDWARD BROWN

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

14. Maiden name SARAH KELLY

15. Birthplace ST. LOUIS  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Thomas Coughlin

(b) Address 5266 MAPLE AVE

17. (a) BURIAL (b) Date thereof FEB 6 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY

18. (a) Signature of funeral director Cullen C. Kelly

(b) Address 4386 LINDELL BLVD

19. (a) JAN 30 1947 (b) J. F. Bredeek  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State MO (b) County BOON  
 (c) City or town ST LOUIS  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 5266 MAPLE AVE. 59  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month January day 29<sup>th</sup>  
 year 1947 hour 8 minute 45 A M.

21. I hereby certify that I attended the deceased from January 22<sup>nd</sup> 1947 to Jan 29 1947  
 that I last saw her alive on January 28<sup>th</sup> 1947  
 and that death occurred on the date and hour stated above.

Immediate cause of death arterio sclerosis 16 yrs  
Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions apoplexy 8 days  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 Belaude H. Allen (M. D. or other) \_\_\_\_\_

Address 5328 Page Blvd Date signed Jan 30 47

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**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. 3977  
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.**