

No. 2
12-45
17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 24 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6296**

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **1446**

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: City Hospital #1
(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

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County St. Louis **5000**
(c) City or town St. Louis
(d) Street No. 5276 Page Blvd. **17**
(If rural, give location) **9**
(e) Citizen of foreign country? _____ (Yes or No) **0**
If yes, name country _____

3. (a) PRINT FULL NAME CATHERINE GARLAND
3. (b) If veteran, name war _____
3. (c) Social Security No. ✓
4. (a) Sex Female 5. Color of race Wh 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife George 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: Feb. 28 1862
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb day 11
year 1947 hour 8:50 minute P. M.
21. I hereby certify that I attended the deceased from Feb 2
1947, to Feb 11, 1947
that I last saw him alive on Feb 11, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Intracranial thrombosis
Due to Arteriosclerosis
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) (e) Means of injury _____
23. Signature W. W. Fitzgerald (M. D. or other) **0**
Address 1515 Lafayette Date signed 2-12-47

8. AGE: Years 84 Months 11 Days 13 If less than one day _____ hr. _____ min.
9. Birthplace Canada (City, town, or county) (State or foreign country)
10. Usual occupation at Home
11. Industry or business _____
12. Name John Moore
13. Birthplace Ireland (City, town, or county) (State or foreign country)
14. Maiden name Mary Gallagher
15. Birthplace Ireland (City, town, or county) (State or foreign country)
16. (a) Informant Mary Agnes Chinnock
(b) Address 5276 Page
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 2-12-47 (Month) (Day) (Year)
(c) Place: burial or cremation St. Ann's Church, W. 12th
18. (a) Signature of funeral director Chas. J. Smart
(b) Address 1225 Union Blvd.
19. (a) FEB 12 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

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

Henry M. Brammer

Licensed Embalmer No. 4200

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.