

FILED NOV 3 1947

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **9819**

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:
De Paul Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**
(c) City or town **St. Louis** (If outside city or town limits, write "RURAL") **17**
(d) Street No. **I478 Rowan Place** (If rural, give location) **9**
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **Mary Coleman**

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
6. (c) Age of husband or wife if alive years

7. Birth date of deceased **October 6th 1889**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
65 0 16 hr. min.

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

10. Usual occupation **Housewife**

11. Industry or business

12. Name **Patrick Grady**

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

14. Maiden name **Jane Cuff**

15. Birthplace **New Orleans, La.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Jennie Pittaluga**

(b) Address **I478 Rowan Place**

17. (a) **Burial** (b) Date thereof **10/25/47**
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director **Sullivan Funeral Dir.**

(b) Address **2849 North Euclid Ave.**

19. (a) **OCT 23 1947** (b) **J. F. Bredack**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **22nd**.
year **1947** hour **2.35** minute **A.M.**

21. I hereby certify that I attended the deceased from **July 10/45**
to **Oct 22/47**
that I last saw **her** alive on **Oct. 22/47**
and that death occurred on the date and hour stated above.

Immediate cause of death **Apoplexy**
Arteriosclerosis, suppurative
Due to **Diabetes of long standing**
Myocarditis

Other conditions
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?
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

23. Signature **J. F. Bredack** (M. D. or other)
Address **1875 Madison** Date signed

Dr. ~~Raley~~

Staff.- De Paul Hospital

B. F. Striegel 90.6.28H

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 *Robert L. Brinkman*

Licensed Embalmer No. *3553*

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.