

FILED DEC 22 1947 **318**

Registrar's No. **11328**

Registration District No. ....

Primary Registration District No. **1002**

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:  
Enroute to 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 30 years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1441 So. 3rd Street  
23 (If rural, give location)  
(e) Citizen of foreign country? ? (Yes or No)  
If yes, name country .....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 10th  
year 1947 hour 2:40 minute P M.

21. I hereby certify that I attended the deceased from .....  
....., 19....., to ....., 19.....;

that I last saw h..... alive on....., 19.....;  
and that death occurred on the date and hour stated above.

Immediate cause of death.....

Cardiac Hypertrophy  
Chronic Myocarditis

Other conditions.....  
(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:

(c) 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?

White at work? (Specify type of place).....  
(d) Means of injury 2  
Signature Patrick E. Taylor, M.D.  
Address 1300 Clark Date signed 11-47

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

3. (a) PRINT FULL NAME Mary Bulback

3. (b) If veteran, name war Nil 3. (c) Social Security No. NONE

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

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

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
abt 56 hr. min.

9. Birthplace Austriall  
(City, town, or county) (State or foreign country)

10. Usual occupation house-wife

11. Industry or business at Home

12. Name unknown 9

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

14. Maiden name unknown

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

16. (a) Informant Michael Bulback

(b) Address 1516 So. 7th Street

17. (a) Burial (b) Date thereof 12-13-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mount Hope Cemetery

18. (a) Signature of funeral director A.W. McLaughlin

(b) Address 2301 Lafayette Ave

19. (a) DEC 11 1947 (Date received local registrar) by J. F. Bredeak (Registrar's signature)

Coroner

**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..... C. W. Cooper.....  
Licensed Embalmer No..... 3830.....  
P. O. Address..... 2301 Lafayette.....

**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.