

No. 2
1/47
5-17-39

National Office of Vital Statistics
FILED JAN 22 1948

Registration District No. 318

Primary Registration District No. 1003

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:
St. John's Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... 13 days
(Specify whether

In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... Missouri (b) County..... St. Louis

(c) City or town..... University
(If outside city or town limits, write "RURAL")

(d) Street No. 1200 Meyer Ave.
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)

If yes, name country.....

3. (a) PRINT FULL NAME..... John Cleeland

3. (b) If veteran, name war..... --

3. (c) Social Security No. --

4. Sex..... Male 5. Color or race..... White

6. (a) Single, widowed, married, divorced..... Widower

6. (b) Name of husband or wife..... Anna Theresa

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

7. Birth date of deceased..... Dec. 4 1867
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
80	1	4	br. min.

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

10. Usual occupation..... Retired

11. Industry or business.....

12. Name..... Unknown

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

14. Maiden name.....

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

16. (a) Informant..... Mrs. Grace Selvaggi

(b) Address..... 1200 Meyer Ave. University

17. (a) Burial (b) Date thereof 1/12/48
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director..... Wacker-Waldhale

(b) Address..... 3634 Gravois Ave.

19. (a) JAN 10 1948 (b) J. F. Brunck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... Jan. day..... 8
year..... 1948 hour..... 8 minute..... 45 P. M.

21. I hereby certify that I attended the deceased from Dec 27, 1947, to Jan 8, 1948
that I last saw him alive on Jan 8, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death..... anaphylactic reaction following serum transfusion

Due to.....

Due to..... Banti's syndrome

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

Major findings:
Of operations..... AB

Of autopsy.....

Duration
1 hr
1 yr

PHYSICIAN

Underline the cause of 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?..... (Specify type of place)

While at work?..... (e) Means of injury..... 6

23. Signature..... W. C. Missey, Jr. (M. D. or other) MD
Address..... 634 Nat. Bank Date signed..... 1/10/48

WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

MOTHER FATHER

LO
7
9

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.....

Frank J. O'Neil

Licensed Embalmer No.....

2645

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.