

FILED MAY 28 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 18085

BIRTH NO. _____ REG. DIST. NO. 217 PRIMARY REG. DIST. NO. 6076 Registrar's No. 936

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) Baden		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
c. LENGTH OF STAY (In this place) _____		d. STREET ADDRESS (If rural, give location) 4844 Bircher	
3. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Halls Ferry Memorial Home			

3. NAME OF DECEASED (Type or Print) Anna	a. (First)	b. (Middle)	c. (Last) Gallagher	4. DATE OF DEATH 4/16/49	(Month) (Day) (Year)
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 12/8/1872	9. AGE (In years last birthday) 76	IF UNDER 1 YEAR Months	IF UNDER 2 HRS. Hours	IF UNDER 15 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY? 0
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13a. FATHER'S NAME James Burns	13b. MOTHER'S MAIDEN NAME Catherine Naughton	14. NAME OF HUSBAND OR WIFE John Gallagher
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME _____ ADDRESS _____
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Apoplexy		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) hypertension DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 3347 83			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from **Jan 19, 1949** to **Apr 16, 1949** that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE M. S. Leaver	(Degree or title) M.D.	23b. ADDRESS Findell Trust Bldg	23c. DATE SIGNED 4-19-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4/19/49	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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DATE REC'D BY LOCAL REG. 4-18-49	REGISTRAR'S SIGNATURE Theresa L. ...	25. FUNERAL DIRECTOR'S SIGNATURE Sullivan Funeral Dir. ADDRESS 2849 Euclid
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *Ernest L. Brubaker*
Licensed Embalmer No. 3523

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.