

FILED JUL 26 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24428

1003 State File No. 6165 Registrar's No.

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) <u>St. Louis</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>	
c. LENGTH OF STAY (In this place) <u>3-mon.</u>		d. STREET ADDRESS (If rural, give location) <u>5370 Pershing Ave.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. John's Hospital</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Edward</u> b. (Middle) <u>W.</u> c. (Last) <u>Colleran</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>July 9, 1951</u>		
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>M.</u>	8. DATE OF BIRTH <u>Jan. 7, 1900</u>	9. AGE (In years last birthday) <u>51</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>2</u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hotel Auditor</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>St. Louis, Mo.</u>	
13a. FATHER'S NAME <u>John Colleran</u>		13b. MOTHER'S MAIDEN NAME <u>Catherine Leonard</u>		14. NAME OF HUSBAND OR WIFE <u>Mrs. Hazel Colleran</u>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>World War # 1</u>		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Hazel Colleran</u> ADDRESS <u>5370 Pershing Ave.</u>	
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH		
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of liver - Metastatic</u>			ANTECEDENT CAUSES			DUE TO (b) <u>Carcinoma Colon</u>		
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.			Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.			DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS			Conditions contributing to the death but not related to the disease or condition causing death.			18 mos		
19a. DATE OF OPERATION <u>July 1950</u>			19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of Transverse Colon</u>			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		

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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>153X</u>	

22. I hereby certify that I attended the deceased from Dec. 26, 1950, to July 9, 1951, that I last saw the deceased alive on July 9, 1951, and that death occurred at 11 p.m., from the causes and on the date stated above.

23a. SIGNATURE <u>Deplance M. Graham, M.D.</u> (Degree or title)		23b. ADDRESS <u>634 N. Grand</u>		23c. DATE SIGNED <u>7-10-51</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>July 13, 1951</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	
24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>		DATE REC'D BY LOCAL REG. <u>JUL 10 1951</u>		REGISTRAR'S SIGNATURE <u>J. B. Foster</u>	
FURNERAL DIRECTOR'S SIGNATURE <u>Arthur J. Donnelly</u>		ADDRESS <u>3840 Lindell Blvd.</u>			

WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

AUG 20 1951

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.....

W H VanMatre

Licensed Embalmer No. *2825*

P. O. Address *4340 Lafajette*

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.