

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **43610**

43610

11177

FILED DEC 24 1952

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

Registrar's No. **11177**

1. PLACE OF DEATH a. COUNTY		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) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis State Hospital		d. STREET ADDRESS (If rural, give location) 13 5400 Arsenal Street	

3. NAME OF DECEASED (Type or Print) a. (First) Ellen b. (Middle) McGillicuddy c. (Last) 13		4. DATE OF DEATH (Month) (Day) (Year) December 4 1952	
--	--	---	--

5. SEX F	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH June 12, 1880	9. AGE (In years last birthday) 72	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
-----------------	-------------------------------	---	---------------------------------------	---	------------------------	----------------------	------------------------	-----------------------

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 (City and State or Foreign Country) Ireland	12. CITIZEN OF WHAT COUNTRY? 4
--	-----------------------------------	---	---------------------------------------

13a. FATHER'S NAME Dont Know	13b. MOTHER'S MAIDEN NAME Dont Know	14. NAME OF HUSBAND OR WIFE John Myer McGillicuddy
-------------------------------------	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Mary Williams	ADDRESS 4214 Dardene Ave.
--	-------------------------------------	--	----------------------------------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION Cerebral vascular accident		INTERVAL BETWEEN ONSET AND DEATH 24 hrs.
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		DUE TO (b) Extreme undernourishment		
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR 331X
---	--	---------------------------------------

22. I hereby certify that I attended the deceased from 11-27, 1950, to 12-4, 1952, that I last saw the deceased alive on 12-4, 1952, and that death occurred at 2-10 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Ellen McGillicuddy	23b. ADDRESS 5400 Arsenal Street	23c. DATE SIGNED 12-4-52
--	---	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12-6-1952	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
---	----------------------------	--	---

DATE REC'D BY LOCAL REG. DEC 4 1952	REGISTRAR'S SIGNATURE Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE Cullinane Bros.	ADDRESS 3320 N. Kingshighway
--	---	---	-------------------------------------

(Licensed Embalmer's Statement on Reverse Side)

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 _____

Fred Frick

Licensed Embalmer No. 3186

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.