

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 29980

FILED AUG 31 1953

7568

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo.</b> b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN <b>St. Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION: <b>St. Anthony Hospital</b>				e. STREET ADDRESS (If rural, give location) <b>15 4403 Miami St.</b>					
3. NAME OF DECEASED (Type or Print) <b>GERALDINE MARIE GALLAGHER</b>			a. (First)		b. (Middle)		c. (Last)		
4. DATE OF DEATH <b>Aug. 2 1953</b>		(Month) (Day) (Year)		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Never Married</b>		8. DATE OF BIRTH <b>March 18, 1952</b>		9. AGE (In years last birthday) <b>1</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>			11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Mo. 0</b>		12. CITIZEN OF WHAT COUNTRY? <b>0</b>	
13a. FATHER'S NAME <b>James F. Gallagher</b>			13b. MOTHER'S MAIDEN NAME <b>Geraldine Buerke</b>			14. NAME OF HUSBAND OR WIFE <b>James F. Gallagher 4403 Miami St.</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME <b>James F. Gallagher</b>			ADDRESS <b>4403 Miami St.</b>	
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Hypertension</b> INTERVAL BETWEEN ONSET AND DEATH <b>18 hrs.</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>?</b> DUE TO (c) <b>?</b> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Adrenal Insufficiency</b> INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs.</b>							
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____						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) <b>343X</b>					
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? _____					
22. I hereby certify that I attended the deceased from <b>8-30 1952</b> , to <b>8-2 1953</b> , that I last saw the deceased alive on <b>8/2 1953</b> , and that death occurred at <b>2:00A</b> m., from the causes and on the date stated above.									
23a. SIGNATURE <b>C. E. Gil O M.D.</b>				(Degree or title)		23b. ADDRESS <b>3211 Orchard</b>		23c. DATE SIGNED <b>8/3/53</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>Aug. 4, 1953</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis Co. Mo.</b>			
DATE REC'D BY LOCAL REG. <b>AUG 3 1953</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Kriegshauser 4228 S. Kingshighway Bl.</b>					

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

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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.....  
Signature of Student Embalmer

Signed

*Edwin A. M. Gerweath*

Licensed Embalmer No.. *3024*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.