

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5862

State File No. 1897

FILED MAR 8 1954

318

1003

1897

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 2 Years		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3225 N. Florissant Ave. Little Sisters of Poor				e. STREET ADDRESS (If rural, give location) 26 3225 No. Florissant Ave. 0			
3. NAME OF DECEASED (Type or Print) a. (First) Marguerite			b. (Middle) Allighen			c. (Last)	
4. DATE OF DEATH (Month) (Day) (Year) Feb. 26, 1954		5. SEX F. / W.		6. COLOR OR RACE W.		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	
8. DATE OF BIRTH Oct. 17, 1869		9. AGE (In years last birthday) 84		IF UNDER 1 YEAR Months Days		IF UNDER 1 HR. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (City and State or Foreign Country) # Ireland	
12. CITIZEN OF WHAT COUNTRY? U.S.				13a. FATHER'S NAME Patrick Tuohy		13b. MOTHER'S MAIDEN NAME Bridget Costello	
14. NAME OF HUSBAND OR WIFE Johnston Allighen				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. 64-797.853	
17. INFORMANT'S SIGNATURE OR NAME Robert Allighen, Chicago, Ill.				ADDRESS			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSES DUE TO (b) <u>Senility</u> Morbidity 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. <u>None</u>				INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u> <u>2 1/2</u>	
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>None</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21d. HOW DID INJURY OCCUR <u>331X</u>	
21e. TIME OF INJURY (Month) (Day) (Year) (Hour) m. <u>None</u>		21f. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22. I hereby certify that I attended the deceased from <u>Feb 12, 1954</u> , to <u>Feb 26, 1954</u> , that I last saw the deceased alive on <u>Feb 19, 1954</u> , and that death occurred at <u>8 1/2</u> m., from the causes and on the date stated above.			
23a. SIGNATURE <u>Samuel L. Howe MD</u>		23b. ADDRESS <u>2435 N. Grand Blvd</u>		23c. DATE SIGNED <u>2-26-54</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Mar. 2, 1954		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
DATE REC'D BY LOCAL REG. MAR 1 1954		REGISTRAR'S SIGNATURE <u>J. Carl Smith MD</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur J. Donnelly</u>		ADDRESS <u>3840 Wendell</u>	

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

(Licensed Embalmer's Statement on Reverse Side)

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 *Francis Williamson*

Licensed Embalmer No. *350*

P. O. Address *St Louis*

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.