

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **29376**

FILED SEP 5 1956

BIRTH NO.		REG. DIST. NO. 317		PRIMARY REG. DIST. NO. 531		Registrar's No. 2019	
1. PLACE OF DEATH a. COUNTY St. Louis				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY St. Louis			
b. CITY (If outside corporate limits, write RURAL and give township) University City			c. LENGTH OF STAY (In this place) 16-yrs.	c. CITY OR TOWN University City		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 7539 Washington Ave.				e. STREET ADDRESS (If rural, give location) 7539 Washington Ave.			
3. NAME OF DECEASED (Type or Print) a. (First) Mary		b. (Middle) Margaret		c. (Last) Breland		4. DATE OF DEATH (Month) (Day) (Year) Aug. 25, 1956	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M.	8. DATE OF BIRTH Mar. 27, 1904		9. AGE (In years last birthday) 52	IF UNDER 1 YEAR Months 4 Days 28	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) housewife-at home		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (City and State or Foreign Country) Scotland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME James Shevlin		13b. MOTHER'S MAIDEN NAME Jeanette Unknown		14. NAME OF HUSBAND OR WIFE Mr. Wilbur Ray Breland			
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 ADDRESS Mr. Wilbur Ray Breland, 7539 Washington Ave.			
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) Acute dilatation of heart ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Alcoholism DUE TO (c) Pulmonary fibrosis; etiological factor unknown. II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 10 yrs. 8 years	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? 3222 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) (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 10-21-40 , 19___, to 8-25-56 , 19___, that I last saw the deceased alive on 8-25-56 , 19___, and that death occurred at 6:10 p.m. from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) F. R. Finnegan M.D.				23b. ADDRESS 539 North Grand Blvd. St. Louis		23c. DATE SIGNED 8-27-56	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Aug. 28, 1956	24c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Missouri		
DATE REC'D BY LOCAL REG. 8-27-56		REGISTRAR'S SIGNATURE Herbert R. Lamb		25. FUNERAL DIRECTOR'S SIGNATURE J. Donnelly		ADDRESS 3840 Lindell Blvd.	
(Licensed Embalmer's Signature on Reverse Side)							

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

10-11-1957
(cancel 11-11)

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 *J. M. Salen*

Licensed Embalmer No. *469*

P. O. Address *3840 L...*

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.