Health, & Welfare Public Service

S. 300 1-57

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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-034038
STATE FILE NUMBER

FILED OCT 3 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9283

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): St.Louis — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): 32 St.Luke's Hospital — Length of stay in 1b: 2-days 2069

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY: /
c. CITY OR TOWN: St.Louis — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 5301 Page Blvd. — Reside on Farm: Yes [ ] No [ ]

3. NAME OF DECEASED (Type or print): First: Helen Middle: Last: Brogan

4. DATE OF DEATH: Month Day Year: Sept.25,1958

5. SEX: F. 1
6. COLOR OR RACE: W.
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] 0 DIVORCED [ ]
8. DATE OF BIRTH: 1872
9. AGE (In years last birthday): 86 — 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): Saleslady,Sonnenfeld's
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Mansfield,Ohio 1
12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME: John Brogan
13b. MOTHER'S MAIDEN NAME: Ann Unknown
14. NAME OF HUSBAND OR WIFE: —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 492-10-7431
17. INFORMANT: Mr.David Lappin, Address: 2334 Noll Drive

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Peritonitis — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Gangrene Sigmoid + Rectum — 24 hrs
DUE TO (c): Arteriosclerosis — years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 450.1
19. WAS AUTOPSY PERFORMED? YES [X] NO [ ] 1

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 9-23-58, to 9-25-58 and last saw her/him alive on 9-25-58
Death occurred at 6 40 a. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Alan McAfee M. D.
22b. ADDRESS: 10010 Euclid Ave
22c. DATE SIGNED: 9/25/58

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: Sept.28,1958
23c. NAME OF CEMETERY OR CREMATORY: St.Peter's Cemetery
23d. LOCATION (City, town, or county) (State): Mansfield,Ohio

24. FUNERAL DIRECTOR: Arthur J. Donnelly — ADDRESS: 3840 Lindell Blvd.
25. DATE RECD. BY LOCAL REG.: SEP 26 '58
26. REGISTRAR'S SIGNATURE: J. Earl Smith, M.D. S.P.

(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 .....

Licensed Embalmer No. .....

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.