

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-033818

FILED VS SEP 16 1959

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 8100**

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, give TOWNSHIP only) OR TOWN St. Louis, Mo.		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jewish Hospital		d. STREET ADDRESS (If outside, give location) 4632a Delmar	

3. NAME OF DECEASED (Type or print) James M. Gallagher		4. DATE OF DEATH Month 8 Day 31 Year 59	
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1-17-1879
9. AGE (last birthday) 80		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Electrical Foreman	11. BIRTHPLACE (City and state or country) Davenport, Iowa
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Patrick Gallagher	13b. MOTHER'S MAIDEN NAME Lida Moore
14. NAME OF HUSBAND OR WIFE Mabel Gallagher		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. 498-10-6236
17. INFORMANT Mrs. Mabel Gallagher		Address 4632a Delmar	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Spontaneous Pneumothoraces, Recurrent		36 hrs.
DUE TO (b) Emphysema with blebs		years
DUE TO (c) 527.1		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
-----------------------------------------------------------------------------------------------------------------------------------	--	----------------------------------------------------------------------------------------------------------------------------------------------------------------------

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	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 8/28/59 to 8/31/59 and last saw her alive on 8/31/59 Death occurred at 4:45 A m on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE (Degree or title) John H. Holt M.D.		22b. ADDRESS 216 S. Kingshighway		22c. DATE SIGNED 9/1/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9-3-59	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) St. Louis, Missouri	

24. FUNERAL DIRECTOR Robert D. Kincaid	ADDRESS 2228 St. Louis Ave	25. DATE RECD. BY LOCAL REG. SEP 1 1959	26. REGISTRAR'S SIGNATURE Loan Smith M.D.
--------------------------------------------------	--------------------------------------	---------------------------------------------------	-----------------------------------------------------

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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

Gustav W. Suetterl

Licensed Embalmer No. 4329

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.