No. 2
1/47
17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 3250

FILED JAN 22 1948

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 430

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

1. PLACE OF DEATH:

(a) County

(b) City or town City ST. Louis.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: City Infirmary Hospital. 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4-30-46/1-14-48 (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 0 0 0

(a) State Missouri. (b) County

(c) City or town City. 17
(If outside city or town limits, write "RURAL")

(d) Street No. 5800 Arsenal St. 9
(If rural, give location)

(e) Citizen of foreign country? No. 13 (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME William, Cooney.

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased ? (Month) ? (Day) ? (Year)

8. AGE: about 78 Years | Months ? | Days ? | If less than one day hr. min.

9. Birthplace (City, town, or county) Unknown (State or foreign country)

10. Usual occupation Attendant, Work

11. Industry or business

FATHER
12. Name Michael ? 4
13. Birthplace Ireland. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Bridget Kenn
15. Birthplace Ireland. (City, town, or county) (State or foreign country) 4

16. (a) Informant City Infirmary Records.
(b) Address 5800 Arsenal St.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1-16-1948 (Month) (Day) (Year)
(c) Place: burial or cremation SUNSET BURIAL PARK

18. (a) Signature of funeral director JAY B SMITH
(b) Address 7465 Manchester Rd.

19. (a) JAN 15 1948 (Date received local registrar) (b) J. F. Bredeak (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 14
year 48 hour 4 minute 45 a. M.

21. I hereby certify that I attended the deceased from 1
1, 1947 to 1-14, 1948
that I last saw him alive on 1-14, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of the prostate — 3 yrs.

Due to

Due to emaciation

Other conditions senility
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause of which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury 0

23. Signature C. P. Shorney (M.D. or other)

Address 5600 Arsenal Date signed 1-14-48

Jefferson City Printing Co.

(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.....

..... Registered Apprentice No.....

working under my personal supervision.

Signed.....J. G. Burgess.....

Licensed Embalmer No.....4029.....

P. O. Address.....Maplewood.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

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

No. 2B
3-45
X43883

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 3259 Feb 1

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 430

1. PLACE OF DEATH:

(a) County
(b) City or town St Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County
(c) City or town
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME William Cooney
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased ? (Month) ? (Day) (Year)
8. AGE: Years 78 Months Days If less than one day hr. min.
9. Birthplace Unknown (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) O. F. Bredeck (Registrar's signature) FEB 3 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month day year 1948 hour minute M.
21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

1948
S-3250