

FILED MAR 19 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 10010Registrar's No. 2055

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. <u>2055</u>			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give town) <u>St. Louis</u>		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>		d. STREET ADDRESS (If rural, give location) <u>5914 West Park</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis State Hospital</u>									
3. NAME OF DECEASED (Type or Print) a. (First) <u>SARAH</u> b. (Middle) <u>FAHEY</u> c. (Last) _____			4. DATE OF DEATH <u>March 2 1949</u>						
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>S.</u>		8. DATE OF BIRTH <u>April 12, 1887</u>			
9. AGE (In years last birthday) <u>61</u>		IF UNDER 1 YEAR Months <u>10</u> Days <u>20</u>		IF UNDER 24 HRS. Mins. _____					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? _____		
13a. FATHER'S NAME <u>Bart Fahey</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Kelly</u>			14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>David F. Collins, 5914 W. Park Ave.</u> 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>Arteriosclerotic Heart Disease</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.  <u>950</u> <u>4271</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1943x</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) _____ m. _____		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 <u>May 28</u> , 19 <u>43</u> , to <u>Mar. 2</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>Mar. 2</u> , 19 <u>49</u> , and that death occurred at <u>7:05 P m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE <u>Jack R. [Signature]</u> (Degree or title) _____				23b. ADDRESS <u>5400 Arsenal St. Louis Missouri</u>		23c. DATE SIGNED <u>3/3/49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Mar. 5, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>			
DATE REC'D BY LOCAL REG. <u>MAR 4 1949</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>380 Lindell Blvd.</u>					

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

**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.

Signed \_\_\_\_\_

*Thomas R. Fenwick*

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 3793

P. O. Address 3840 Lindell

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