

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6640

State File No.

FILED MAR 4 1952

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **1014**

| | | | |
|---|--|---|----------------|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY ST. LOUIS | |
| b. CITY (If outside corporate limits, write RURAL and give town) ST. LOUIS | c. LENGTH OF STAY (in this place) 8 hrs | a. CITY (If outside corporate limits, write RURAL and give township) MAPLEWOOD | b. 4544 |
| d. FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL | | d. STREET ADDRESS (If rural, give location) 3505 OXFORD AVE | |

| | | | | | | | |
|---|-------------------------------|---|----------------------------------|---|---|---|--------------------------------------|
| 3. NAME OF DECEASED (Type or Print) a. (First) PETER | | b. (Middle) C | | c. (Last) MOONEY | | 4. DATE OF DEATH (Month) (Day) (Year) 1 31 52 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED | 8. DATE OF BIRTH 12-22-86 | | 9. AGE (In years last birthday) 65 | IF UNDER 1 YEAR Months 1 Days 7 | IF UNDER 18 HRS. Hours 7 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN | | 10b. KIND OF BUSINESS OR INDUSTRY NONE | | 11. BIRTHPLACE (State or foreign country) OHIO | | 12. CITIZEN OF WHAT COUNTRY? U.S.A | |

| | | | | | |
|--|--|---|--|---|--|
| 13a. FATHER'S NAME PETER MOONEY | | 13b. MOTHER'S MAIDEN NAME BRIDGETT FRAWLEY | | 14. NAME OF HUSBAND OR WIFE CARMA MOONEY | |
|--|--|---|--|---|--|

| | | | | | |
|---|--|---|--|----------------------------|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) NONE | 17. INFORMANT'S SIGNATURE OR NAME CARMA MOONEY | | ADDRESS 3505 OXFORD | |
|---|--|---|--|----------------------------|--|

| | | | | | |
|---|--|---|--|--|--|
| 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, asphyxia, etc. It means the disease, injury, or complication which caused death. | | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ecchymia perfer general failure | | INTERVAL BETWEEN ONSET AND DEATH 1 week | |
| ANTECEDENT CAUSES | | DUE TO (b) Generalized Coronarui | | 9 mo | |
| | | DUE TO (c) Ca Prostate | | 2 years | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | Chronic myocarditis | | 10 yrs. | |
| | | Arteriosclerotic heart | | | |

| | | | | |
|------------------------|----------------------------------|--|--|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? 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) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? 177X | |
|---|--|--|--|

22. I hereby certify that I attended the deceased from **9-6**, 19**46** to **1-31**, 19**52**, that I last saw the deceased alive on **1-31**, 19**52**, and that death occurred at **1:52** p.m., from the causes and on the date stated above.

| | | |
|---|--------------------------------------|--------------------------------|
| 23a. SIGNATURE (Degree or title) William W Farley MD | 23b. ADDRESS 3108 50th ground | 23c. DATE SIGNED 2-1-52 |
|---|--------------------------------------|--------------------------------|

| | | | | |
|--|-------------------------|---|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL | 24b. DATE 2-2-52 | 24c. NAME OF CEMETERY OR CREMATORY LAKEWOOD PARK | 24d. LOCATION (City, town, or county) (State) ST. LOUIS COUNTY MO | |
|--|-------------------------|---|--|--|

| | | | | |
|--|--|---|--|--|
| DATE REC'D BY LOCAL REG. FEB 1 1952 | REGISTRAR'S SIGNATURE Carl Smith MD | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS JAY B SMITH - 7456 MANCHESTER, MAPLEWOOD, MO. | | |
|--|--|---|--|--|

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.

Student
Student Embalmer

Signed.....

W.P. 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 with the above constitutes grounds for revocation of license.)

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