

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

**24452**

FILED JUL 20 1953

State File No. \_\_\_\_\_

BIRTH NO. 42183-53 REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 657

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, write RURAL and give town) <u>Springfield</u>	c. LENGTH OF STAY (In this place) <u>3 days</u>	c. CITY (If outside corporate limits, write RURAL and give township) <u>Springfield</u> <u>0396</u> <u>0</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. John's Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>412 South Fort</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Catherine</u>	b. (Middle) <u>Sue</u>	c. (Last) <u>Mahoney</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>7-14-53</u>		
--	------------------------	--------------------------	---	--	--

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>7-10-53</u>		9. AGE (In years) (Month) (Day) (Hour) (Min.) <u>3</u> <u>2</u> <u>40</u>	
----------------------	-------------------------------	---	------------------------------------	--	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>St. John's Hospital Springfield, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
--	--	--	--	--	--

13a. FATHER'S NAME <u>Thomas Edward Mahoney</u>	13b. MOTHER'S MAIDEN NAME <u>Geraldine Robinson</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>		
--	--	--	--	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Mahoney</u>		ADDRESS <u>412 South Fort</u>	
---	--	--	--	----------------------------------	--

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				INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Prematurity</u>					
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUE TO (b) <u>6 1/2 mo. pregnancy</u> <u>2 1/2 lbs.</u>				
DUE TO (c)					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>776 x</u>			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)	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 7-10-53, 1953, to 7-14-53, 1953, that I last saw the deceased alive on 7-13-53, 1953, and that death occurred at 5:10 AM, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>E. J. Schwartz M.D.</u>	23b. ADDRESS <u>609 Cherry, Springfield Mo.</u>	23c. DATE SIGNED <u>7-14-53</u>
--	--	------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>July 14, 1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn</u>	24d. LOCATION (City, town, or county) (State) <u>Springfield, Mo.</u>	
--	-----------------------------------	--	--	--

DATE REC'D BY LOCAL REG. <u>7-15-53</u>	REGISTRAR'S SIGNATURE <u>Edith Williamson</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>J. Klingner &amp; Co. Springfield Mo.</u>		ADDRESS
--	--	--	--	---------

(Licensed Embalmer's Statement on Reverse Side)

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

E. 071

**STATEMENT BY LICENSED EMBALMER**

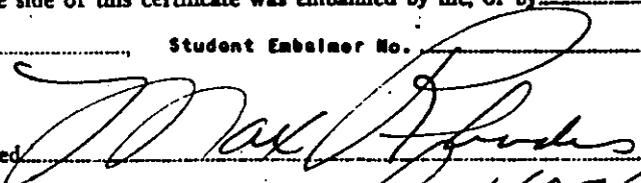
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

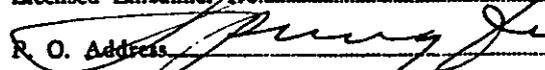
Signed \_\_\_\_\_



Licensed Embalmer No. \_\_\_\_\_

4071

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