

FILED NOV 22 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 39055  
Registrar's No. 9732

318

1003

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____		
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY _____				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <b>St. Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION: <b>St. Louis City Hospital</b>				e. STREET ADDRESS (If rural, give location) <b>4932 Hooke Ave. 2079</b>				
3. NAME OF DECEASED (Type or Print) a. (First) <b>Mary</b> b. (Middle) _____ c. (Last) <b>Mulcahy</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Oct. 24, 1954</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Never Married</b>		8. DATE OF BIRTH <b>May 13, 1874</b>		
9. AGE (In years last birthday) <b>80</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 1 HR. Hours _____ Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13a. FATHER'S NAME <b>John Mulcahy</b>			13b. MOTHER'S MAIDEN NAME <b>Ann Slevin</b>		14. NAME OF HUSBAND OR WIFE <b>None</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Queenie Keane, 4932 Hooke Ave.</b> 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) <b>Coronary Thrombosis, Subarachnoid Hemorrhage, due to cerebral aneurysm fall from bed to floor while a patient</b> ANTECEDENT CAUSES <b>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</b> DUE TO (c) <b>City Hospital #1. on October 24, 1954, at about 5:00 pm Accident</b>					INTERVAL BETWEEN ONSET AND DEATH _____	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT (Specify) <b>Accident</b>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Asap</b>		21c. (CITY, TOWN, OR TOWNSHIP), (COUNTY) (STATE) <b>St. Louis Mo</b>				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>Oct 24 54 5:00</b>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>E 9027</b>				
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>9:55</b> m., from the causes and on the date stated above. <b>45</b>								
22a. SIGNATURE <b>Patrick Taylor Carson</b> (Degree or title) _____				22b. ADDRESS <b>1300 Clark</b>		22c. DATE SIGNED <b>10-26-54</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>10-27-54</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Walvary</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>		
DATE REC'D BY LOCAL REG. <b>OCT 26 1954</b>		REGISTRAR'S SIGNATURE <b>J. Earl Smith, M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Harrigan-Sheahan, 4700 Washington Bl</b> ADDRESS _____				

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

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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 *E. J. Resmelius*.....

Licensed Embalmer No. *42*.....

P. O. Address *P. O. Box*.....

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.