

FILED DEC 16 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **42601**  
Registrar's No. **10589**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE b. COUNTY	
b. CITY OR TOWN <b>St. Louis, Mo.</b>		c. CITY OR TOWN <b>St. Louis, Mo.</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>4747 Beacon</b>		STREET ADDRESS (If rural, give location) <b>3613a Finney Ave.</b>	
3. NAME OF DECEASED (Type or Print) <b>Catherine Mahony.</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Nov. 19, 1954.</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Never Married</b>	8. DATE OF BIRTH <b>Oct. 14, 1873</b>
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>Ireland</b>
13a. FATHER'S NAME <b>Timothy Hill</b>		13b. MOTHER'S MAIDEN NAME <b>Ellen Hill</b>	14. NAME OF HUSBAND OR WIFE

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. Anthony Pusateri</b>	ADDRESS <b>4747 Beacon</b>
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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.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary artery disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs +</b>	
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>General arterio sclerosis</b>			<b>2 yrs +</b>
	DUE TO (c)			
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Gangrene of both feet</b>		<b>2 weeks</b>	
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) <b>442X</b>
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 **May 24, 1954**, to **Nov 19, 1954**, that I last saw the deceased alive on **Nov 17, 1954**, and that death occurred at **3.25 P m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>Reumer Kane</b>	(Degree or title)	23b. ADDRESS <b>1117 N Grant</b>	23c. DATE SIGNED <b>11/20/54</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>Nov. 22, 1954</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Calvary</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis Mo.</b>
DATE REC'D BY LOCAL REG. <b>NOV 22 1954</b>	REGISTRAR'S SIGNATURE <b>Carl Smith MD</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>J. J. Quinn</b> ADDRESS <b>1380 Union Bldg</b>	

(Licensed Embalmer's Signature on Reverse Side)

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 Ben C. Hoffman  
Licensed Embalmer No. 431

P. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.