

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2209

State File No.

FILED JAN 11 1955

BIRTH NO. _____ REG. DIST. NO. 310 PRIMARY REG. DIST. NO. 3058 Registrar's No. 35-

1. PLACE OF DEATH a. COUNTY <u>St. Charles</u> <u>0</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Charles</u>		c. CITY OR TOWN <u>St. Louis</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Joseph Hospt.</u>		STREET ADDRESS (If rural, give location) <u>4300 Hebert</u> <u>0-079</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Mary</u>	b. (Middle) <u>F</u>	c. (Last) <u>Moran</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>1/3/55</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>3/28/1889</u>	9. AGE (In years last birthday) <u>65</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Hospt.</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>New Harford, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Frank Hayden</u>	13b. MOTHER'S MAIDEN NAME <u>Ann Hughes</u>	14. NAME OF HUSBAND OR WIFE <u>James Moran Dec.</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>Unk</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>James Moran Rt #1 Box 448 Robertson</u>
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 mo</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Lymphosarcoma - Disseminated</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) _____ rise to the above cause (a) stating the underlying cause last. 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 <u>Aug 1954</u>	19b. MAJOR FINDINGS OF OPERATION <u>BIOPSY - Lymphosarcoma</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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 Aug 19, 1954, to Jan 3, 1955, that I last saw the deceased alive on Jan 2, 1955, and that death occurred at 3:20a m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>John G. McNamee M.D.</u>	23b. ADDRESS <u>10300 St. Charles Rd, St. Louis, Mo</u>	23c. DATE SIGNED <u>Jan 3, 1955</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>1/6/55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Wellsville Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Wellsville, Missouri</u>
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>Jan 3 1955</u>	REGISTRAR'S SIGNATURE <u>Francis Hamilton</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>W. W. Mark 1125 Hadjiamont St. St. Louis Mo.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

JUN 25 1961

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 *Alfred J. Boedeker*

Licensed Embalmer No. *266*

P. O. Address *1125 1/2 1st St*

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.