

FILED MAY 6 - 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

318

1003

14623
STATE FILE NUMBER 1266

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>St. Louis</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
f. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Missouri Baptist 2 wks</i>		Length of stay in lb	17 ^a STREET ADDRESS (If inside, give location) <i>4125 De Soto</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>Elizabeth</i> Middle _____ Last <i>Dohoney</i>			4. DATE OF DEATH Month <i>4</i> Day <i>19</i> Year <i>57</i>		
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1/15/1887</i>	9. AGE (In years last birthday) <i>70</i>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, open if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>self</i>	11. BIRTHPLACE (City and state or country) <i>Ireland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Edward Mahoney</i>			14. MOTHER'S MAIDEN NAME <i>don't know</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. _____	17. INFORMANT <i>Mrs. Marie Coe 4125 De Soto</i>		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterio Sclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Fracture of Left Hip</i> DUE TO (c) <i>E9040</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>21</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <i>1/2</i>

20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Suffered in fall at home</i>	
20c. TIME OF INJURY Hour <i>7</i> a. m. _____ p. m. _____ Month, Day, Year <i>3 4 57</i>	<i>March 4 1957</i>	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <i>17 Home</i>	20f. CITY, TOWN, OR LOCATION <i>St. Louis Mo.</i>

21. I attended the deceased from _____ to _____ and last saw her/him alive on _____
Death occurred at *330k* m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>James M Kelly Deputy</i>	22b. ADDRESS <i>1300 Clark</i>	22c. DATE SIGNED <i>4-20-57</i>
---	-----------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>4/22/57</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Resurrection</i>	23d. LOCATION (City, town, or county) (State) <i>St. Louis County Mo.</i>
---	-----------------------------	---	--

24. FUNERAL DIRECTOR <i>Jos. A. Howard 1619 So. Grand</i>	25. DATE RECD. BY LOCAL REG. <i>APR 20 '57</i>	26. REGISTRAR'S SIGNATURE <i>J. Earl Smith md</i>
--	---	--

(Licensed Embalmer's Statement on Reverse Side)

S. 300
v. 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Security and medical certificates are required by 195.140 works 1949.

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 *Joseph A. Howard*.....

Licensed Embalmer No. *41*

P. O. Address *ST. LOUIS*

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.