

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15596

FILED APR 29 1957

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 993

1. PLACE OF DEATH a. COUNTY <u>St. Louis</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, give TOWNSHIP only) OR TOWN <u>Kirkwood 22.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Kirkwood 22, 4703</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>602 Angenette</u>			Length of stay in lb <u>3 1/2 yrs</u>		d. STREET ADDRESS <u>602 Angenette</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JAMES PATRICK CAHILL</u>				First	Middle	Last	4. DATE OF DEATH <u>April 15 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 19, 1884</u>		9. AGE (In years last birthday) <u>72</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>15</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief Prop. Deputy</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>State Of Mo.</u>		11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Cahill</u>				14. MOTHER'S MAIDEN NAME <u>Marcella O'Fallon</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>496-30-6302</u>		17. INFORMANT <u>A James I. Smith 602 Angenette.</u>			Address <u>Kirkwood 22</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> <u>Congestive heart failure</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE, CONDITION GIVEN IN PART I (a) <u>4/201</u>							INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>1-2 years</u>	
20a. ACCIDENT <input 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.)					
20c. TIME OF INJURY Hour <u></u> Month, Day, Year a. m. <u></u> p. m. <u></u>								
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.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE				
21. I attended the deceased from <u>4.11.57</u> to <u>4.15.57</u> and last saw her <u>alive</u> on <u>4.14.57</u> Death occurred at <u>3:30 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>Herbert B. Dumble MD</u>				22b. ADDRESS <u>1695 BRENTWOOD BLVD, BRENTWOOD, MO.</u>		22c. DATE SIGNED <u>4.15.57</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)			
<u>Removal</u>		<u>4-17-57</u>	<u>Calvary Cem.</u>		<u>St. Louis Mo.</u>			
24. FUNERAL DIRECTOR <u>Pfizinger Mort.</u>			ADDRESS <u>331 S. Kirkwood</u>		25. DATE RECD. BY LOCAL REG. <u>4-15-57</u>	26. REGISTRAR'S SIGNATURE <u>Herbert B. Dumble MD</u>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Health, & Welfare
Public
Services
S. 300
V. 1-58
All
diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All
diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.
securing the medical certification in the specific manner required by 193.100 WORKS 1957.

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 E. Hoffmann*.....

Licensed Embalmer No. *430*

P. O. Address *Green Co*

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.