

5. No. 100  
v. 10 28

FILED JUN 7 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **18636**  
**4583**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>Uplanda Park 41600</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Firmin Desloge Hospital</b>		d. STREET ADDRESS (If rural, give location) <b>3619 Ridge Dale Dr.</b>	
3. NAME OF DECEASED a. (First) <b>James</b> b. (Middle) <b>F</b> c. (Last) <b>Feeney</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>May 11 1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Nov. 25 1879</b>
9. AGE (In years last birthday) <b>77</b>		IF UNDER 1 YEAR Month <b>5</b> Day <b>16</b>	IF UNDER 1000 Hrs. Hours <b>16</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <b>Ireland</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>Martin Feeney</b>	
13b. MOTHER'S MAIDEN NAME <b>Sarah Quigley</b>		14. NAME OF HUSBAND OR WIFE <b>Ethel Feeney</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>493-01-3291</b>	
17. INFORMANT'S SIGNATURE OR NAME <b>Ethel Feeney</b>		ADDRESS <b>3619 Ridge Dale Dr.</b>	
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 Disease</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>arteriosclerosis</b> DUE TO (c) <b>arterial hypertension</b> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>encephalomalacia</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>420.1</b>	
20. AUTOPSY? YES <input checked="" 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)	
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 <b>Jan.</b> , 19 <b>57</b> , to <b>May</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>May 11</b> , 19 <b>57</b> , and that death occurred at <b>10:50 P.M.</b> , from the causes and on the date stated above.			
23a. SIGNATURE <b>John R. Howard</b>		23b. ADDRESS <b>502 N. Chace</b>	
23c. DATE SIGNED <b>7/14/57</b>			
24a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>5-14-1957</b>	
24c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis Mo.</b>	
DATE REC'D BY LOCAL REG. <b>MAY 14 57</b>		REGISTRAR'S SIGNATURE <b>Carl Smith</b>	
25. FUNERAL DIRECTOR'S SIGNATURE <b>Cullinane Bros.</b>		ADDRESS <b>3320 N. Kingshighway</b>	

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

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 \_\_\_\_\_  
Student Embalmer

Signed

*Fred Frick*

Licensed Embalmer No. 3186

P. O. Address St. Louis, Mo.

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 this body is not embalmed, fact should be so stated above.