

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUL 31 1957

STATE FILE NUMBER
26221
6743

Registration District No. **318** Primary Registration District No. **1003** Registrar's No.

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN ST. LOUIS, MO.	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 25 ST. LOUIS CITY HOSP # 1		Length of stay in lb 1		d. STREET ADDRESS 224 G STREET 2811a Chouteau (If outside, give location)	
3. NAME OF DECEASED (Type or print) First JOCLIE Middle Last IVY			4. DATE OF DEATH Month July Day 16 Year 1957		
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 15 1885	9. AGE (In years last birthday) 71 IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY retired		11. BIRTHPLACE (City and state or country) Miss.	
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Rosa Hennison		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. no		17. INFORMANT Address ST. LOUIS CITY HOSP # 1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL EMBOLISM Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE WITH AURICULAR FIBRILLATION DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n)					INTERVAL BETWEEN ONSET AND DEATH 2 DAYS
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.) 420.0		
20c. TIME OF INJURY Hour, Month, Day, Year a. m. p. m.					
20d. INJURY OCCURRED WHILE AT <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 7/14/57 to 7/16/57 and last saw her alive on 7/16/57 Death occurred at 10: p. m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Daniel J. Mulhally, M.D.			22b. ADDRESS 1515 LAFAYETTE AVE.		22c. DATE SIGNED 7/17/57.
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 22 July 1957		23c. NAME OF CEMETERY OR CREMATORY Washington Park	
24. FUNERAL DIRECTOR Reliable Funeral Sys. 1389 N. Union		25. DATE RECD. BY LOCAL REG. JUL 19 57		23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.	
26. REGISTRAR'S SIGNATURE J. Carl Smith M.D.					

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

502

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: *Paul V. Freeman*

Licensed Embalmer No. 468

P. O. Address 4729 Hamu

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.