

FILED SEP 4 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

30486

STATE FILE NUMBER

Registration District No. 312 Primary Registration District No. 500 Registrar's No. 1967

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lemay</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Woodson Terrace</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Lemay Nursing Home-3<math>\frac{1}{2}</math> Mon.</u>				Length of stay in lb <u>3<math>\frac{1}{2}</math> Mon.</u>		d. STREET ADDRESS (If outside, give location) <u>9222 Tutwiler</u>	
3. NAME OF DECEASED (Type or print) First <u>CECELIA</u> Middle <u></u> Last <u>O'MALLEY</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>7</u> Year <u>1957</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sep. 30, 1872</u>		9. AGE (In years last birthday) <u>84</u>		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (City and state or country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Geraghty</u>				14. MOTHER'S MAIDEN NAME <u>Catherine O'Toole</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>None</u>		17. INFORMANT <u>Mrs. Sarah Banks</u> Address <u>6013 Pennsylvania</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>Cerebral Thrombosis</u> Conditions, if any, which pertain to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>3 yrs</u> <u>14 yrs</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 <u></u> Day <u></u> Year <u></u> 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>January 3, 1957</u> , to <u>August 7, 1957</u> and last saw <sup>her</sup> <u>him</u> alive on <u>August 7, 1957</u> . Death occurred at <u>3:15 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Michael L. Barwick M.D.</u>				22b. ADDRESS <u>7615 Le Broadway</u>		22c. DATE SIGNED <u>8/8/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>Aug. 9, 1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>	
24. FUNERAL DIRECTOR <u>Kriegshauser</u> ADDRESS <u>4228 S. Kingshighway</u>				25. DATE RECD. BY LOCAL REG. <u>8-9-57</u>		26. REGISTRAR'S SIGNATURE <u>Herbert B. Domlehn</u>	

(Licensed Embalmer's Statement on Reverse Side)

1th,  
alfare  
lic  
vice00  
56

diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

89

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was  
by me, or by ..... Student Embalmer No. ....  
working under my personal supervision.

Student.....  
Signature of Student Embalmer

Signed *Richard W. Stone*

Licensed Embalmer No. 44

P. O. Address .....

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.