

Health,
& Welfare
Public
Health Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38751

FILED OCT 16 1957

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2403

S. 300
v. 57
4000
4

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>Manchester</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Maplewood</u> 4544 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>Manchester Nursing Home</u>		Length of stay in lb <u>9-days</u>	d. STREET ADDRESS (If outside, give location) <u>7366 Maple</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Kate</u> Middle <u>A.</u> Last <u>McCloskey</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>29</u> Year <u>1957</u>		
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5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</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>July 26, 1871</u>	9. AGE (In years last birthday) <u>86</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>3</u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telegrapher</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>& Co.</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
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13a. FATHER'S NAME <u>John Rice</u>	13b. MOTHER'S MAIDEN NAME <u>Margaret Murphy</u>	14. NAME OF HUSBAND OR WIFE <u>Mr. Charles Carter McCloskey</u>
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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>497-03-3784</u>	17. INFORMANT <u>Mr. G.S. McCloskey</u>	Address <u>654 Oakland, Webster Groves</u>
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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>CARDIO-VASCULAR DISEASE</u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>SENILITY</u>	<u>4221</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>NONE</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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.)
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20c. TIME OF INJURY Hour <u> </u> Month, Day, Year a.m. <u> </u> p.m. <u> </u>	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 <u> </u>	COUNTY <u> </u>	STATE <u> </u>
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21. I attended the deceased from <u>SEPT 20, 1957</u> to <u>SEPT 29, 1957</u> and last saw her/him alive on <u>SEPT 28, 1957</u> Death occurred at <u>2:05 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>B.P. Loving M.D.</u>	(Degree or title) <u> </u>	22b. ADDRESS <u>BALLWIN, Mo.</u>	22c. DATE SIGNED <u>9-29-57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Oct. 2, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u>
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24. FUNERAL DIRECTOR <u>Arthur J. Donnelly</u>	ADDRESS <u>3840 Lindell Blvd.</u>	25. DATE RECD. BY LOCAL REG. <u>9-30-57</u>	26. REGISTRAR'S SIGNATURE <u>Dorbert B. Donnelly M.D.</u>
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(Licensed Embalmer's Statement on Reverse Side)

89.

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Da. 7-2304

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 Francis Williams

Licensed Embalmer No. 3565

P. O. Address 3840 Lead

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.