

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

38759  
STATE FILE NUMBER

FILED OCT 30 1957

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2507

Health, & Welfare Public Service  
S. 300 v. 1-56  
4  
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>MANCHESTER</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>ST LOUIS,</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>37 PINE CREST NURSING</b>		Length of stay in 1b <b>5 DAYS</b>		d. STREET ADDRESS (If outside, give location) <b>5634 COTE BRILLIANTE</b>		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOHANNA A. MORAN</b>				4. DATE OF DEATH <b>OCT 10, 1957</b>		Month Day Year	
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>FEB, 22, 1879</b>	
9. AGE (In years last birthday) <b>78</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (City and state or country) <b>ST LOUIS MISSOURI</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>PATRICK GOGGIN</b>				14. MOTHER'S MAIDEN NAME <b>CATHERINE SKEVINGTON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yrs, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>490-03-6407a</b>		17. INFORMANT Address <b>MRS CATHERINE BRESLIN 5634 COTE BRILLIANTE</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF RIGHT BREAST WITH METASIS</b>							INTERVAL BETWEEN ONSET AND DEATH <b>?</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b)		DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>SENILITY</b>							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.)				
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year							
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 <b>OCT. 1, 1957</b> to <b>OCT 10, 1957</b> and last saw her/him alive on <b>OCT. 9, 1957</b> Death occurred at <b>6:45 A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>B. R. Loving M. D.</b>				22b. ADDRESS <b>Ballwin, Mo.</b>		22c. DATE SIGNED <b>10-10-57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>10/12/57</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CALVARY CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>ST LOUIS MISSOURI</b>	
24. FUNERAL DIRECTOR ADDRESS <b>STROOT - CARROLL 4600 NATURAL BRIDGE</b>			25. DATE RECD. BY LOCAL REG. <b>10-10-57</b>		26. REGISTRAR'S SIGNATURE <b>Hebert R. Somhe</b>		

*Dr. Lawrence  
Monmouth  
La. 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 *MWR B. meter*

Licensed Embalmer No. *486*

P. O. Address *St. Louis*

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.