

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-007736
STATE FILE NUMBER

FILED FEB 28 1958

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1626

300
1-57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
All diseases in Part I must be causally related.

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|--|----------------------------------|---|---|--|--|
| 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 checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| 25 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John Hospital | | Length of stay in 1b 229 0 | d. STREET ADDRESS 4828 Milentz | | (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last Florence H. Rooney | | | 4. DATE OF DEATH Month Day Year Feb. 10, 1958 | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 13, 1891 | | 9. AGE (In years last birthday) 67 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper | | 10b. KIND OF BUSINESS OR INDUSTRY V.L. McCormick | | 11. BIRTHPLACE (City and state or country) St. Louis, Missouri | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13a. FATHER'S NAME John Rooney | | 13b. MOTHER'S MAIDEN NAME Ella Coughlin | |
| 14. NAME OF HUSBAND OR WIFE None | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown | | 16. SOCIAL SECURITY NO. Unknown | |
| 17. INFORMANT Address Mrs. William Schiller-Mehlville, Mo. | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Pneumonia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Pulmonary Emphysema DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 5271 | | | |
| 19. INTERVAL BETWEEN ONSET AND DEATH 8-10 days yes | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Month, Day, Year a.m. p.m. | | 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | | |
| 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 June 5-7 to Feb 10 58 and last saw her ^{her} _{him} alive on Feb 10 58 Death occurred at 1:15P m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE Samuel A. Munsch MD (Degree or title) | | | 22b. ADDRESS 35 W Central Clayton Mo | | 22c. DATE SIGNED 2-10-58 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Feb. 13, 1958 | 23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | | 23d. LOCATION (City, town, or county) (State) St. Louis, Missouri |
| 24. FUNERAL DIRECTOR ADDRESS WACKER-HELDERLE-3634 Gravois Ave. | | | 25. DATE RECD. BY LOCAL REG. FEB 11 58 | | 26. REGISTRAR'S SIGNATURE Carl Smith MD |

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 *Frank J. Hand*

Licensed Embalmer No. *2675*

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.