

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-016941
STATE FILE NUMBER

FILED APR 21 1958

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1021

1. PLACE OF DEATH a. COUNTY ST LOUIS,		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY ST LOUIS,	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN CARSONVILLE		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN FLORISSANT 4000
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION PENN NUR. HOME		Length of stay in 1b 7 WKS	d. STREET ADDRESS (If outside, give location) 210 SO JEFFERSON
3. NAME OF DECEASED (Type or print) Thomas (none shown) Maginness		4. DATE OF DEATH Month Day Year APRIL 12, 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 22, 1872
9. AGE (In years last birthday) 85		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) Retired Loco Engineer		10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (City and state or country) IRELAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. MOTHER'S MAIDEN NAME UNKNOWN	
13a. FATHER'S NAME UNKNOWN		14. NAME OF HUSBAND OR WIFE W.N.K.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	17. INFORMANT Address HARRIET YERKEY 210 SO JEFFERSON FLORISSANT 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) ARTERIOSCLEROTIC HEART DISEASE DUE TO (b) ARTERIOSCLEROSIS DUE TO (c) 4200			INTERVAL BETWEEN ONSET AND DEATH years years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e)			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 Month, Day, Year a.m. p.m.		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 FEB 18 58 to APRIL 11-58 and last saw him alive on APRIL 7 1958 Death occurred at B A m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) R. B. Shannon M.D.		22b. ADDRESS 1755 SO GRAND	22c. DATE SIGNED 4-12-58
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 4/15/58	23c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY
23d. LOCATION (City, town, or county) (State) ST LOUIS MISSOURI		24. FUNERAL DIRECTOR ADDRESS STROOT - CARROLL 4600 NATURAL BRIDGE	
25. DATE RECD. BY LOCAL REG. 4-14-58		26. REGISTRAR'S SIGNATURE Herbert P. Donke M.D.	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 M W Rueter

Licensed Embalmer No. 4865
P. O. Address St Louis Mo

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.