

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-023526
STATE FILE NUMBER

FILED JUN 30 1958

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5915

5. 300
1-57
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|--|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | c. CITY OR TOWN <u>University City</u> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Missouri Baptist Hosp.</u> | | Length of stay in 1b | d. STREET ADDRESS <u>8059 Teasdale</u> <u>4376</u> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Ella Mahaney</u> | | 4. DATE OF DEATH <u>June 9, 1958</u> | |
| 5. SEX <u>female</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct. 2, 1883</u> |
| 9. AGE (In years last birthday) <u>74</u> | | 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) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u> | 11. BIRTHPLACE (City and state or country) <u>Fairplay, Missouri</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13a. FATHER'S NAME <u>Oliver T. Sproul</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>Elizabeth Hopkins</u> | | 14. NAME OF HUSBAND OR WIFE <u>Joseph T. Mahaney</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>Joseph T. Mahaney</u> | | Address <u>8059 Teasdale Ave.</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>Arricular or Ventricular Tachycardia</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>Months</u> |
| Conditions, if any, which gave rise to above cause (a), stating the under- lying cause last. | | | DUE TO (b) <u>parathyropituitary State</u> <u>years</u> |
| DUE TO (c) <u>Resection of Craniopharyngioma</u> <u>years</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>224X</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.) | |
| 20c. TIME OF INJURY Hour a.m. p.m. | | 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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>Feb 19 57</u> to <u>June 9 1958</u> and last saw her ^{him} alive on <u>June 8 1958</u> Death occurred at <u>4:35 a.m. June 9 1958</u> on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <u>Ray David Williams MD</u> | | 22b. ADDRESS <u>114 North Taylor St. Louis 8 MO</u> | |
| 22c. DATE SIGNED <u>9 June 58</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | | 23b. DATE <u>6-10-58</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Oakgrove Cemetery</u> | | 23d. LOCATION (City, town, or county) <u>St. Louis Co. Mo.</u> | |
| 24. FUNERAL DIRECTOR <u>C.R. Lupton and Sons 7233 Delmar</u> | | 25. DATE RECD. BY LOCAL REG. <u>JUN 9 '58</u> | |
| 26. REGISTRAR'S SIGNATURE <u>J. Carl Smith MD</u> | | | |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related. No symptoms will be listed.

18-3-8600
9:00 to 10:00 A.M.

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 Arnold W. Schoene

Licensed Embalmer No. 3864
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.