

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-030479  
STATE FILE NUMBER

SEP 15 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7736

1. PLACE OF DEATH a. COUNTY <u>                    </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>SAINT LOUIS</u> <u>6</u>		c. CITY OR TOWN <u>ST. LOUIS</u> <u>4161</u> 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>14 JEWISH HOSPITAL OF ST. LOUIS</u>		d. STREET ADDRESS (If outside, give location) <u>27 2129 67th St</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
Length of stay in lb. <u>18 days</u>			
3. NAME OF DECEASED (Type or print) First <u>GENEVIEVE</u> Middle <u>X</u> Last <u>HANRAHAN</u>		4. DATE OF DEATH Month <u>AUG.</u> Day <u>8</u> Year <u>1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</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>11/23/1898</u>
9. AGE (In years last birthday) <u>79</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	11. BIRTHPLACE (City and state or country) <u>ILL.</u>
10a. USUAL OCCUPATION		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13a. FATHER'S NAME <u>ERNEST GERARD</u>		13b. MOTHER'S MAIDEN NAME <u>MARY LOUVIERE</u>	
14. NAME OF HUSBAND OR WIFE <u>James (Dec)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>                    </u>	
17. INFORMANT Address <u>MRS WESTER WALKER 2129 67th ST</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>STAPHYLOCOCCAL PNEUMONIA</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>RIGHT COLON RESECTION</u>			<u>8 DAYS</u>
DUE TO (c) <u>CARCINOMA OF RIGHT COLON</u>			<u>15 DAYS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>PAROTITIS 1530</u>			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.) <u>                    </u>	
20c. TIME OF INJURY Hour <u>                    </u> Month, Day, Year a.m. <u>                    </u> p.m. <u>                    </u>			
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.) <u>                    </u>	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>24 JULY 58</u> to <u>8 AUG. 58</u> and last saw her <sup>her</sup> <sub>him</sub> <u>8 AUG 58</u> Death occurred at <u>11:52 a</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Andrew McCane, MDD</u> (Degree or title)		22b. ADDRESS <u>216 S. Kingshighway St. Louis, MO</u>	
22c. DATE SIGNED <u>8 Aug 58</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>8-11-58</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>CALVARY</u>		23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS, MO.</u>	
24. FUNERAL DIRECTOR <u>A. KRON LIVERY-UNDERTAKING CO</u> <u>2707 N. GRAND</u>		25. DATE RECD. BY LOCAL REG. <u>AUG 9 '58</u>	
26. REGISTRAR'S SIGNATURE <u>Earl Smith MO</u> <u>MJB.</u>			

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

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 *Hester J. San Jr.* .....

Licensed Embalmer No. *4800* .....

P. O. Address *Wickham Rd* .....

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.