Health, Welfare Public Service

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1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-041474
STATE FILE NUMBER

FILED DEC 5 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11176

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Inside Limits: Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): St. Louis City Hosp. #1 — Length of stay in Ib: 25

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY: St. Louis
c. CITY OR TOWN: Breckenridge Hills 4221 — Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 3016 Woodson — Reside on Farm: Yes ☐ No ☐ — 27

3. NAME OF DECEASED (Type or print): First: Thomas; Middle: F.; Last: Dolan

4. DATE OF DEATH: Month: November; Day: 18; Year: 1958

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Oct. 20, 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): Caretaker

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and state or country): Ireland 4

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Patrick Dolan

13b. MOTHER'S MAIDEN NAME: Mary Murray

14. NAME OF HUSBAND OR WIFE: Annie nee O'Reilly

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 493-10-8557

17. INFORMANT: Mrs. Annie Dolan — Address: 3016 Woodson

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Aspiration pneumonia

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Epidermoid carcinoma of tongue
DUE TO (c) 141.9

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE 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 Aug. 13, 1958, to Nov. 18, 1958 and last saw her/him alive on Nov. 18, 1958. Death occurred at 7:30 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Rhys A. Williams, M.D.

22b. ADDRESS: 1515 Lafayette Ave.

22c. DATE SIGNED: 11/19/58

23a. BURIAL, CREMATION, REMOVAL (Specify): burial

23b. DATE: 11-20-58

23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery

23d. LOCATION (City, town, or county) (State): St. Louis, Mo.

24. FUNERAL DIRECTOR: H. Sullivan — ADDRESS: 1150 N. Kingshighway

25. DATE REC'D BY LOCAL REG.: NOV 20 1958

26. REGISTRAR'S SIGNATURE: Karl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 .....

Licensed Embalmer No. .....

P. O. Address .....

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.