

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-042801

STATE FILE NUMBER

FILED DEC 10 1958 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3199

5. 300
1-57

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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 Cool Valley		c. CITY OR TOWN Cool Valley 4000	
c. FULL NAME OF HOSPITAL OR INSTITUTION 1501 S. Florissant Hill Top House		d. STREET ADDRESS Hill Top Nursing Home 1501 S. Florissant	
3. NAME OF DECEASED Nursing Home (Type or print) MARGARET CLOONEY		4. DATE OF DEATH December 5, 1958	
5. SEX Female	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 Dec. 26, 1874
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (City and state or country) XXXXXX St. Louis, Mo
13a. FATHER'S NAME Charles Lehman		13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE Wm. J. Clooney, Deceased
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Jos. Clooney, 2540 Normandy Drive
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accidents, multiple DUE TO (b) _____ DUE TO (c) 331X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Generalized arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH -
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. _____		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from Mar 10 - 1958 to Dec 4 - 1958 and last saw her Dec 3 - 1958 Death occurred at 3:50 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Blue G M Finney MD (Degree or title)		22b. ADDRESS 5014 Thekla Av	
22c. DATE SIGNED 12/4/58			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-8-58	
23c. NAME OF CEMETERY OR CREMATORY St. Peter's Cemetery		23d. LOCATION (City, town, or county) (State) Normandy, Missouri	
24. FUNERAL DIRECTOR Stock Mortuary, 2117 E. Grand Bl ADDRESS		25. DATE RECD. BY LOCAL REG. 12-8-58	
		26. REGISTRAR'S SIGNATURE Herbert B. Donahoe Sr.	

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 *Paul A. Wachtel*

Licensed Embalmer No. *24787*
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.