

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-046588
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 3445

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>		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>CLAYTON</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>VALLEY PARK</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. LOUIS CO. HOSPITAL</u>		Length of stay in 1b <u>18 HRS.</u>	d. STREET ADDRESS (If outside, give location) <u>674 MARSHALL AVE</u>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>LEVINIA</u> Middle <u>MARGARET</u> Last <u>KEARLEY</u>			4. DATE OF DEATH Month <u>12</u> Day <u>31</u> Year <u>58</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 type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 3, 1895</u>	
9. AGE (In years last birthday) <u>63</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 - INVALID</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	11. BIRTHPLACE (City and state or country) <u>ST. LOUIS, MO.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>JOS. CULAHAN</u>		
13b. MOTHER'S MAIDEN NAME <u>ANNA BOCK</u>		14. NAME OF HUSBAND OR WIFE <u>VAUGHN KEARLEY</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>UNKNOWN</u>		17. INFORMANT <u>MARIE CULAHAN #5 WINNETKA</u>
		Address <u>GLENDALE</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>Pulmonary Infarction, left lower lobe</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12/30/58</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Arteriosclerotic Heart Disease</u>		
DUE TO (c) _____		<u>12/31/58</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Loobar Pneumonia, left upper lobe 4200</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 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 <u>ST. LOUIS</u>	COUNTY <u>ST. LOUIS</u>	STATE <u>MO.</u>
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21. I attended the deceased from 12-30-58 to 12-31-58 and last saw her alive on 12-31-58
Death occurred at 12:15 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Angelo A. Speno M.D.</u>	(Degree or title)	22b. ADDRESS <u>601 So. Brentwood</u>	22c. DATE SIGNED <u>1/1/59</u>
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23a. BURIAL, CREATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>1-7-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>VAL HALLA CEMETERY</u>	23d. LOCATION (City, town, or county) <u>ST. LOUIS COUNTY MO.</u>
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24. FUNERAL DIRECTOR <u>Mittelsberg Funeral Home</u>	ADDRESS <u>Webster Groves, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>1-1-59</u>	26. REGISTRAR'S SIGNATURE <u>Herbert R. Donke M.D.</u>
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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.

NOT EMBALMED

Student
Signature of Student Embalmer

Signed Chas. J. Cox

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.