Health, Welfare Public Service

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-003147

STATE FILE NUMBER

FILED FEB 10 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 954

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: St. Louis — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): DePaul Hospital — Length of stay in Hospital: 2199

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY:
c. CITY OR TOWN: St. Louis — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 378 N. Taylor — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: Mary Middle: Eulah Last: Kearney

4. DATE OF DEATH: Month: January Day: 26 Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: August 12, 1895

9. AGE (In years last birthday): 63 — 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): Masseuse

10b. KIND OF BUSINESS OR INDUSTRY: Massage Parlor

11. BIRTHPLACE (City and state or country): Missouri

12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME: William L. Maples

13b. MOTHER'S MAIDEN NAME: Delia P. Crowe

14. NAME OF HUSBAND OR WIFE: Harry

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.: Unknown

17. INFORMANT: Harry Kearney, Address: Newtonia, Mo.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia + Hepatic coma. — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Hemolytic Anemia — 3 mo.
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 292.0

19. WAS AUTOPSY PERFORMED? YES [X] 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 Nov 58, to JAN 26-59 and last saw her/him alive on JAN 26-59
Death occurred at 12:10 a m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: D. Oetter (Degree or title) MD

22b. ADDRESS: 730 Hedgemont

22c. DATE SIGNED: 1-27-59

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

23b. DATE: 1-26-59

23c. NAME OF CEMETERY OR CREMATORY: Odd Fellows Cemetery

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

24. FUNERAL DIRECTOR: Albert H. Hoppe, ADDRESS: 4700 Washington Blvd.

25. DATE RECD. BY LOCAL REG.: JAN 27 '59

26. REGISTRAR'S SIGNATURE: H. Carl Smith MD M.S.B.

(Licensed Embalmer's Statement on Reverse Side)

MAR 26 1959

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 J. Wm. Binkley
J. Wm. Binkley

Licensed Embalmer No. 3653

P. O. Address [illegible]

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.