

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-003579

STATE FILE NUMBER

2 1026

FILED FEB 16 1959

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH a. COUNTY		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 St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Wellston 4316
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Faith Hospital		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 1271 Ryan Terrace
3. NAME OF DECEASED (Type or print) First Middle Last Patrick Michael Tiernan			4. DATE OF DEATH Month Day Year Jan. 28, 1959
5. SEX Male	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 Feb. 28, 1883
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night Watchman		10b. KIND OF BUSINESS OR INDUSTRY St. Vincent's Hosp.	11. BIRTHPLACE (City and state or country) Ireland 4
13a. FATHER'S NAME Michael Tiernan		13b. MOTHER'S MAIDEN NAME Mary Sweeney	14. NAME OF HUSBAND OR WIFE Ellen
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or Unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 497-07-7832	17. INFORMANT Address Eugene J. Tiernan 7507 Liberty (4)
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion			INTERVAL BETWEEN ONSET AND DEATH 1/23/59
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 420.1			
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 <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2
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 Month, Day, Year 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	COUNTY STATE
21. I attended the deceased from 1/25/59 to 1/27/59 and last saw him alive on 1/28/59 Death occurred at 7:07 AM m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Joseph A. Costantino M.D.		22b. ADDRESS 2407a N. Broadway, St. Louis 6, Mo.	22c. DATE SIGNED 1/28/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 1/31/59	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
24. FUNERAL DIRECTOR Chas. F. Stuart		ADDRESS 1225 Union	25. DATE RECD. BY LOCAL REG. JAN 29 1959
			26. REGISTRAR'S SIGNATURE Earl Smith M.D.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

S. P.

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 *Elton H. Remeliso*

Licensed Embalmer No. *4283*

P. O. Address *H. Davis, W.*

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.