THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007303
STATE FILE NUMBER 2 1509

FILED MAR 2 1959

Registration District No. ..... Primary Registration District No. ..... Registrar's No. .....

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St.Louis — Inside Limits: Yes X No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): 6009 McPherson Ave. — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY: /
c. CITY OR TOWN: St.Louis — Inside Limits: Yes X No ☐
d. STREET ADDRESS (If outside, give location): 6009 McPherson Ave. — Reside on Far: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First Teresa — Middle Z — Last Keleher
4. DATE OF DEATH: Month Day Year Feb.11,1959
5. SEX: F.
6. COLOR OR RACE: W.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED X 2 DIVORCED ☐
8. DATE OF BIRTH: April 4th.1888
9. AGE (In years last birthday): 70 — 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): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (City and state or country): St.Louis Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Patrick Barrett
14. MOTHER'S MAIDEN NAME: Bridget - Kinniss
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Mrs. Charles Moran — Address: 6009 McPherson

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): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 3 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b): Coronary Sclerosis (angina) — 5 yr
DUE TO (c): Interstitial Nephritis Chronic
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 592X
19. WAS AUTOPSY PERFORMED? YES ☐ NO X

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 1958, to Feb 11-59 and last saw her/him alive on 2-11-59
Death occurred at 8 P. m on the date stated above; and to the best of my knowledge, from the causes stated

22a. SIGNATURE (Degree or title): Mark J. Flores M.D.
22b. ADDRESS: 706 Olive St.
22c. DATE SIGNED: 2/12/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 2-14-1959
23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery
23d. LOCATION (City, town, or county) (State): St.Louis,Missouri

24. FUNERAL DIRECTOR: Arthur J. Donnelly — ADDRESS: 1840 Lindell Blvd.
25. DATE RECD. BY LOCAL REG.: FEB 13 '59
26. REGISTRAR'S SIGNATURE: Earl Smith. M.D.

(Licensed Embalmer's Statement on Reverse Side)

M. D. 3.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was

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.
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.