

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007409
STATE FILE NUMBER
2 1866

FILED MAR 10 1959

Registration District No. _____ Primary Registration District No. _____ Registrar No. _____

300
-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2154 Allen Ave</u>		Length of stay in lb <u>5yrs</u>	d. STREET ADDRESS (If outside, give location) <u>2154 Allen Ave</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Michael</u> Middle <u>Mackin</u> Last <u>Mackin</u>			4. DATE OF DEATH Month <u>Feb</u> Day <u>20</u> Year <u>1959</u>		
--	--	--	---	--	--

5. SEX <u>Male</u> <input checked="" type="checkbox"/>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 15 1869</u>	9. AGE (In years from birthday) <u>90</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>Freight Handler</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Mo Pac</u>	11. BIRTHPLACE (City and state or country) <u>Ireland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U S</u>
---	--	--	--

13a. FATHER'S NAME <u>Patrick Mackin</u>	13b. MOTHER'S MAIDEN NAME <u>Nora Barnicle</u>	14. NAME OF HUSBAND OR WIFE <u>None</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>-</u>	17. INFORMANT <u>Mrs Thomas Judge</u> Address <u>2154 Allen Ave</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>Arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr - 5 mo.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Heart Arteriosclerosis</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>420.0</u>		19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO

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 <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 <u>8-29-58</u> to <u>2-20-59</u> and last saw ^{him} <u>her</u> alive on <u>2-10-59</u> . Death occurred at <u>12 noon</u> on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE <u>James P. Murphy, M.D.</u> (Degree or title)	22b. ADDRESS <u>634 W. Grand</u>	22c. DATE SIGNED <u>2-21-59</u>

23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2/24/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St Louis Missouri</u>
---	-----------------------------	---	---

24. FUNERAL DIRECTOR <u>Moydell Funeral Home 1926 Allen</u>	25. DATE RECD. BY LOCAL REG. <u>FEB 24 '59</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u> M. J. B.
--	---	--

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 me....., Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed George J. Seabode Jr......
Licensed Embalmer No. 4899.....
P. O. Address 1926 Allen.....

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.