

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-008499
STATE FILE NUMBER

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 351

300

-57

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Joseph</u> <u>0117</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>St. Joseph's Hosp.</u>		Length of stay in lb <u>70 Yrs</u>	d. STREET ADDRESS (If outside, give location) <u>1602 No. 18th St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>BRIDGETT</u> Middle <u>MALONEY</u> Last <u>MALONEY</u>			4. DATE OF DEATH Month <u>April</u> Day <u>4</u> Year <u>1959</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 checked="" type="checkbox"/> 2. DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 3, 1863</u>	9. AGE (In years last birthday) <u>95</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (City and state or country) <u>Kansas City, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Michael Rahaley</u>		13b. MOTHER'S MAIDEN NAME <u>Jane McNamara</u>		14. NAME OF HUSBAND OR WIFE <u>Cornelius Maloney</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>None</u>		17. INFORMANT Address <u>Mrs E.J. Bode 1602 No. 18th City</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>cerebro-vascular accident</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>arterio-sclerotic cardiovascular disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4.2.1</u>					INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
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 <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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>March 27, 1959</u> to <u>April 4, 1959</u> and last saw her/him alive on <u>April 4, 1959</u> Death occurred at <u>5:25 P m</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Gene E. Michel, M.D.</u>			22b. ADDRESS <u>46 C. L. Grant Lindenwood Lane, St. Joseph, Mo.</u>		22c. DATE SIGNED <u>Apr. 6, 1959</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Apr. 7, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		23d. LOCATION (City, town, or country) (State) <u>St. Joseph, Mo.</u>
24. FUNERAL DIRECTOR <u>H.O. Seligman & Son R.R.1.</u>		ADDRESS <u>St Joseph, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>April 6, 1959</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Goodell</u>

All diseases in Part I must be causally related.

Dr. Gene E. Michel

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.

Student
Signature of Student Embalmer

Signed *W. William Davis*

Licensed Embalmer No. *4195*

P. O. Address *St. Joseph, Mo.*

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.