

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015350

STATE FILE NUMBER

23674

FILED MAY 8 1959 Registration District No. Primary Registration District No. Registrar's No.

300
1-57

5

S

20

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 checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis 4000
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Johns Hospt		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 9709 Glen Owens Dr
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last Maureen McCarthy			4. DATE OF DEATH Month Day Year 4-14-59			
--	--	--	---	--	--	--

5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-13-59	9. AGE (In years last birthday) 12	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) None	10b. KIND OF BUSINESS OR INDUSTRY *****	11. BIRTHPLACE (City and state or country) St. Louis Missouri	12. CITIZEN OF WHAT COUNTRY? USA
---	--	--	-------------------------------------

13a. FATHER'S NAME John McCarthy	13b. MOTHER'S MAIDEN NAME Mariclare Monhan	14. NAME OF HUSBAND OR WIFE None
-------------------------------------	---	-------------------------------------

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. None	17. INFORMANT John McCarthy	Address 9709 Glen Owens Dr.
---	---------------------------------	--------------------------------	--------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Erythroblastosis Fetalis</i>		INTERVAL BETWEEN ONSET AND DEATH 11 1/2 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	770.0
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 checked="" type="checkbox"/> NO <input type="checkbox"/>

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 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 4/13/59 to 4/14/59 and last saw ^{per}him alive on 4/14/59
Death occurred at 3:00 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Bunch H. Merritt M.D.</i>	(Degree or title)	22b. ADDRESS 7309 Natural Bridge Rd	22c. DATE SIGNED 4/14/59
--	-------------------	--	-----------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4-14-59	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) St. Louis, Missouri
---	----------------------	--	--

24. FUNERAL DIRECTOR J.W. Clark F.H. 1125 Hodiament Ave.	ADDRESS	25. DATE RECD. BY LOCAL REG. APR 14 '59	REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>
---	---------	--	--

(Licensed Embalmer's Statement on Reverse Side)

m. & 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, 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. (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.