

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-016074
STATE FILE NUMBER

FILED MAY 8 1959 Registration District No. 317 Primary Registration District No. 541 Registrar's No. 1232

300
1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) Clayton		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Fenton Mo. 4008
c. FULL NAME OF (If NOT in hospital, give location) St. Louis Co. Hosp. 2 weeks		Length of stay in lb 2 weeks	d. STREET ADDRESS (If outside, give location) 1094 Hwy. 66
3. NAME OF DECEASED (Type or print) First MARY Middle Ann Last REED			4. DATE OF DEATH Month 5 Day 2 Year 1959
5. SEX Female	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 11/26/1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) Poland 4
13a. FATHER'S NAME John F. Mocny		13b. MOTHER'S MAIDEN NAME Katherine -unknown	14. NAME OF HUSBAND OR WIFE Deceased
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. 493-20-6887	17. INFORMANT Address Mrs. Margaret Hirsch Fenton Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Hypertensive Cardiovascular Disease DUE TO (c) 443X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 1 Cerebro-vascular accident 2 Post-OP mid-thigh amputation 3 Deep Vein Thrombosis			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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. Month, Day, Year _____			
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 4-15-59 , to 5-2-59 and last saw her/him alive on 5-2-59 8:40 P.M. Death occurred at 8:40 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) John E. Oakley, M.D.		22b. ADDRESS 601 BRENTWOOD BLVD.	22c. DATE SIGNED 5/2/59
23a. NAME OF CEMETERY OR CREMATORY Burial		23b. DATE 5/6/59	23c. NAME OF CEMETERY OR CREMATORY Calvary
23d. LOCATION (City, town, or country) St. Louis		(State) Mo.	
24. FUNERAL DIRECTOR Leop. Fieser Fenton Mo		25. DATE RECD. BY LOCAL REG. 5-4-59	26. REGISTRAR'S SIGNATURE John P. Murphy M.D.

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 *Donnie J. Mahan*

Licensed Embalmer No. *4326*
P. O. Address *Helena, MT*

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.