

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-022789

STATE FILE NUMBER

FILED JUN 24 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. **5564**

300  
1-57

57.4

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>7</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b>		d. STREET ADDRESS (If outside, give location) <b>1035A <del>St.</del> Goodfellow</b>	
Length of stay in 1b		Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Jonathan</b> Middle _____ Last <b>Cooney</b>			4. DATE OF DEATH Month <b>6</b> Day <b>4</b> Year <b>59</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-4-59</b>		9. AGE (In years last birthday) IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours <b>10</b> Min. <b>41</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Saint Louis, Missouri</b>	
13a. FATHER'S NAME <b>Raymond Cooney</b>		13b. MOTHER'S MAIDEN NAME <b>Opal Jean Buchanan</b>		14. NAME OF HUSBAND OR WIFE	

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Mary Jett, P.R.L. 2601 N. Whittier</b>	
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Premature birth, Neonatal death</b>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		<b>773.5</b>
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 _____ a.m. _____ p.m. Month, Day, Year _____			20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE

21. I attended the deceased from **6-4-59** to **6-4-59** and last saw <sup>him</sup> **him** alive on **6-4-59**  
Death occurred at **4:45** p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Park White</b> (Degree or title) <b>M. D.</b>	22b. ADDRESS <b>2601 N. Whittier</b>	22c. DATE SIGNED <b>6-5-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>6-30-59</b>	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY <b>Anatomical Board</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>
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24. FUNERAL DIRECTOR <b>Rowland Akew 4104 Manchester</b>	25. DATE RECD. BY LOCAL REG. <b>JUN 11 '59</b>	26. REGISTRAR SIGNATURE <b>Earl Smith, M.D.</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.