

**RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**  
**FILED VS AUG 11 1959**

**59-026976**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 7094**

<b>1. PLACE OF DEATH</b> a. COUNTY		<b>2. USUAL RESIDENCE</b> (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>		Length of stay in 1b	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>1181 N. Union</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1181 N. Union</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>James Mooney</u>			<b>4. DATE OF DEATH</b> Month Day Year <u>July 30 1959</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>7-22-1865</u>	<b>9. AGE</b> (last birthday) <u>94</u>	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HR</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Packer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Retired</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Ireland</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>

<b>13a. FATHER'S NAME</b> <u>William Mooney</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>Ann Rogers</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>Sarah Mooney</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>498-07-7506</u>		<b>17. INFORMANT</b> Address <u>Mary Mooney 1181 N. Union</u>	

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chr. Myocarditis</u> DUE TO (b) <u>Chr. Intestinal Aneurysm</u> DUE TO (c) <u>592+</u>			<b>INTERVAL BETWEEN ONSET AND DEATH</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			

<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH</b> but not related to the terminal disease condition given in PART I (a)		<b>PART III. If deceased was female was there a pregnancy in last 90 days.</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)	
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. Month, Day, Year		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE	

**21. I attended the deceased from** Aug 1958 to July 1959 and last saw her/him alive on July 28, 1959  
 Death occurred at 9 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> (Degree or title) <u>Robert A. Kell M.D.</u>		<b>22b. ADDRESS</b> <u>3901 W. Florissant</u>		<b>22c. DATE SIGNED</b> <u>7/31/59</u>
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>	<b>23b. DATE</b> <u>8-3-59</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Calvary</u>	<b>23d. LOCATION</b> (City, town, or county) (State) <u>St. Louis Mo</u>	
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Biesiek-Niehaus 1131 N. Union</u>		<b>25. DATE RECD. BY LOCAL REG.</b> <u>JUL 31 1959</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>Carl Smith, M.D.</u>

DED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Elmer R. Padua

Licensed Embalmer No. 4077

P. O. Address St Louis

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.