

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-027717

FILED VS AUG 3 1959

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1916 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Normandy</u>	Length of stay in 1b <u>1 da.</u>	c. CITY OR TOWN <u>Berkeley</u>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Normandy Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>8032 Airport Rd.,</u>	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Unnamed</u> Middle <u>Maloney</u> Last <u>Maloney</u>	4. DATE OF DEATH Month <u>7</u> Day <u>16</u> Year <u>1959</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7/16/59</u>	9. AGE (last birthday) IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u>	IF UNDER 24 HR Hours <u>2</u> Min. <u>2</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Normandy, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>John Maloney</u>	13b. MOTHER'S MAIDEN NAME <u>Janet Phillipps</u>	14. NAME OF HUSBAND OR WIFE
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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 <u>John Maloney-8032 Airport Rd., Berkeley, Mo.</u>	Address
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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:		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a)	<u>Cerebral anoxia</u>		<u>1 hr</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Respiratory failure</u>		<u>1 hr</u>
	DUE TO (c) <u>prematurity</u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input 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.)
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20c. TIME OF INJURY Hour <u>8:01</u> a.m. Month, Day, Year <u>7-16-59</u>	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 <u>Berkeley, Mo.</u>	COUNTY	STATE
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21. I attended the deceased from <u>7-16-59</u> to <u>7-16-59</u> and last saw her alive on <u>7-16-59</u> Death occurred at <u>8:01</u> a. m. on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>A. H. Olson</u> (Degree or title)	22b. ADDRESS <u>6401 W. Florissant</u>	22c. DATE SIGNED <u>7-17-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>7/17/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>	23d. LOCATION (City, town, or county) <u>St. Louis County, Mo.</u>
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24. FUNERAL DIRECTOR <u>White-Mullen Mortuary, Ferguson, Mo.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>7-17-59</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy, MD</u>
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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 me  
or by Not embalmed, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed Reinhold K. Lohman

Licensed Embalmer No. 3395

P. O. Address Ferguson 3

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.