

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 6 1959

59-037850

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's **210083**

ENDED

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, MISSOURI		c. CITY OR TOWN Frontenac Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If outside, give location) 10343 Anzieger Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First ELEANORA Middle NMN Last MAHON			4. DATE OF DEATH Month NOVEMBER Day 1 Year 1959			
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5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10/31/1900	9. AGE (last birthday) 59	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) St. Charles, Mo.	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Jacob Fetsch	13b. MOTHER'S MAIDEN NAME Caroline Schwendemann	14. NAME OF HUSBAND OR WIFE Oscar Mahon
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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) No	16. SOCIAL SECURITY NO. 491-26-4731	17. INFORMANT Mrs. Ralph Ritter, 10447 Garibaldi, Frontenac Mo.
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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 3 DAYS
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE	
DUE TO (c) 420.0		12 1/2 YEARS

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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 _____ 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 _____
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21. I attended the deceased from **NOV. 19, 1957** to **NOV. 1, 1959** and last saw her alive on **NOV. 1, 1959**
Death occurred at **9:30 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Charles M. D.</i> (Degree or title)	22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 11/2/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 11/4/59	23c. NAME OF CEMETERY OR CREMATORY St. Peter Cemetery	23d. LOCATION (City, town, or county) (State) Kirkwood, Mo.
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24. FUNERAL DIRECTOR <i>Levas H. Dapp, Inc., Kirkwood</i>	25. DATE RECD. BY LOCAL REG. NOV 3 1959	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>
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M. B.

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 _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Francis J. Maglind
Licensed Embalmer No. 4512
P. O. Address Kirkwood

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.