

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-038394

LED VS NOV 2 1959

317

Primary Registration District No.

547

Registrar's No.

2790

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Richmond Hgts. (17) Mo.		Length of stay in 1b 11 days	c. CITY OR TOWN Richmond Hgts. (17) Mo. Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1269 Moorlands Dr. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First JULIA Middle MAHONY Last MAHONY			4. DATE OF DEATH Month Oct. Day 19 Year 1959			
5. SEX F.	6. COLOR OR RACE W.	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Apr. 3, 1885	9. AGE (last birthday) 74	IF UNDER 1 YEAR Months 6 Days 16	IF UNDER 24 HR Hours 16 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY U. S. A.
13a. FATHER'S NAME William Reed		13b. MOTHER'S MAIDEN NAME Mary Tighe		14. NAME OF HUSBAND OR WIFE Patrick Mahony		

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. 495-44-8404	17. INFORMANT Phillip Mahony Address 1269 Moorlands Dr.
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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) Pneumia		INTERVAL BETWEEN ONSET AND DEATH 101.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Pyelonephritis + Arterio	
	DUE TO (c) nephrosclerosis	
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

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.)
20c. TIME OF INJURY Hour 4:15 PM Month, Day, Year 10/18/59	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 St. Louis, Mo.	COUNTY	STATE
21. I attended the deceased from 10/18/59 to 10/19/59 and last saw her ^{her} _{him} alive on 10/19/59 "Death occurred at 4:15 PM on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE (Degree or title) Malcolm B. Howell M.D.	22b. ADDRESS 4660 MARYLAND	22c. DATE SIGNED 10-21-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Personal	23b. DATE Oct. 22, 1959	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery
23d. LOCATION (City, town, or county) St. Louis, Mo.		(State)

24. FUNERAL DIRECTOR A.H. Bocklage ADDRESS 6536 Clayton Rd.	25. DATE RECD. BY LOCAL REG. 10-21-59	26. REGISTRAR'S SIGNATURE John C. Murphy M.D.
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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 _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Lawrence P. Herk

Licensed Embalmer No. 4979

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.