

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 045709

FILED VS. JAN. - 4 1960

211861

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		Length of stay in 1b	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If outside, give location) 4492 FOREST PARKWAY	
3. NAME OF DECEASED (Type or print) First IDA Middle E. Last MALONEY		4. DATE OF DEATH Month DECEMBER Day 21 Year 1959	
5. SEX FEMALE	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12-19-1885
9. AGE (last birthday) 74		10. KIND OF BUSINESS OR INDUSTRY AT HOME	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		11. BIRTHPLACE (City and state or country) ??	
13a. FATHER'S NAME John STROT		13b. MOTHER'S MAIDEN NAME ?? ALLEN	
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. UNK	
17. INFORMANT John F. MALONEY		Address 4308 STEINS ST.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) 420.0 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 10 YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) CONGESTIVE HEART FAILURE AND PULMONARY EDEMA			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 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.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	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
21. I attended the deceased from JUNE 14, 1955 to DEC. 21, 1959 and last saw her Death occurred at 5:40 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) C. D. Vermillion, M.D.		22b. ADDRESS BARNES HOSPITAL	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23c. NAME OF CEMETERY OR CREMATORY MISSOURI CREMATORY	
23b. DATE 12-23-1959		23d. LOCATION (City, town, or county) (State) 3211 Sulltan. ST. LOUIS, MO.	
24. FUNERAL DIRECTOR Beeghler Bros 6408 Graves.		25. DATE RECD. BY LOCAL REG. DEC 22 1959	
		26. REGISTRAR'S SIGNATURE Kean Smith, M.D.	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

STATE OF MISSOURI

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 Van M. Seizemer

Licensed Embalmer No. 7343

P. O. Address St. Louis Mo

Note: The above **MUST** BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.