

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-009335

FILED VS. MAR 3 1960 317

Registration District No. 590 Primary Registration District No. 453 Registrar's No.

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 Rock Hill		Length of stay in 1b 3 Yrs		c. CITY OR TOWN Rock Hill		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Rock Hill Rest Home			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Rock Hill Rest Home		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last HANNAH HIGGINS MALONEY				4. DATE OF DEATH Month Day Year Feb. 9, 1960			
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 1-6-1867	9. AGE (last birthday) 93	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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) Amboy Ill.		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Henry Higgins			13b. MOTHER'S MAIDEN NAME Anne Brady			14. NAME OF HUSBAND OR WIFE William Maloney	
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. None		17. INFORMANT Anne Redmond Address 6900 Crandon Ave. Chicago 49, Ill.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic heart disease							INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) - DUE TO (c) -							
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 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 a.m. p.m. 7:45 PM		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
21. I attended the deceased from 8-21-56 to 2-9-60 and last saw her him alive on 2-8-60 Death occurred at 7:45 PM m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE a T. Merfem M.D. (Degree or title)				22b. ADDRESS 3707 Poloma		22c. DATE SIGNED 2-11-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 2-11-1960	23c. NAME OF CEMETERY OR CREMATORY St. Patricks Cenetery		23d. LOCATION (City, town, or county) (State) Amboy Illinois		
24. FUNERAL DIRECTOR Parker-Aldrich Webster Groves Mo. ADDRESS				25. DATE RECD. BY LOCAL REG. 2-11-60		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

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 Leslie Welch

Licensed Embalmer No. 439

P. O. Address Holston, Tenn

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.