

**R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**=60-017809**

**FILED VS APR 22 1960**

STATE FILE NUMBER

Registration District No. **317** Primary Registration District No. **500** Registrar's No. **1177**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>St. Louis</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Normandy</b>		Length of stay in 1b <b>1 year</b>		c. CITY OR TOWN <b>Normandy</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>3410 St. Thomas More Lane</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>3410 St. Thomas More Lane</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Lulu</b> Middle <b>Maguire</b> Last <b>Maguire</b>				<b>4. DATE OF DEATH</b> Month <b>April</b> Day <b>7</b> Year <b>1960</b>				
<b>5. SEX</b> <b>female</b>	<b>6. COLOR OR RACE</b> <b>white</b>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>11-11-1872</b>	<b>9. AGE (last birthday)</b> <b>87</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>homemaker</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>At Home</b>	<b>11. BIRTHPLACE</b> (City and state or country) <b>Warsaw, Illinois</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>		
<b>13a. FATHER'S NAME</b> <b>Jacob Pohl</b>			<b>13b. MOTHER'S MAIDEN NAME</b> <b>Catherine Stracer</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>deceased</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b> <b>-</b>		<b>17. INFORMANT</b> Address <b>Eugene J. Dreiling, 3410 St. Thomas More Lane</b>				
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio Sclerotic Heart Disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>20 yrs</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Diabetes Mellitus</b>						<b>20 yrs</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 type="checkbox"/> N. <input type="checkbox"/> Unknown		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)						
<b>20c. TIME OF INJURY</b> Hour _____ s.m. _____ p.m. _____	Month, Day, Year _____							
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		COUNTY _____	STATE _____	
<b>21. I attended the deceased from</b> <b>July 1957</b> to <b>Apr. 1960</b> and last saw her <b>alive on Apr 6, 1960</b> Death occurred at <b>3:00 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.								
<b>22a. SIGNATURE</b> (Degree or title) <b>M D Johnson M D</b>				<b>22b. ADDRESS</b> <b>Ferguson Mo</b>		<b>22c. DATE SIGNED</b> <b>4-8-60</b>		
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Removal</b>		<b>23b. DATE</b> <b>April 11, 1960</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Calvary Cemetery</b>		<b>23d. LOCATION</b> (City, town, or county) <b>St. Louis Missouri</b>		(State)	
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>Math Hermann &amp; Son, Inc., 2161 E. Fair</b>				<b>25. DATE RECD. BY LOCAL REG.</b> <b>APR 9 1960</b>	<b>26. REGISTRAR'S SIGNATURE</b> <b>John C. Murphy M.D.</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 \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Clement McNeary

Licensed Embalmer No. 3732

P. O. Address A. Lane

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