

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-020903

FILED VS MAY 25 1960

318

Primary Registration District No. 1003

Registrar's No. 4946

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>65-yrs.</b>	c. CITY OR TOWN <b>St. Louis</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>DePaul Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1935 Forest Ave.</b>
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Faherty</b> Last			4. DATE OF DEATH Month <b>May</b> Day <b>9th.</b> Year <b>1960</b>		
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4/22/1883</b>	9. AGE (last birthday) <b>77</b>	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Fort Wayne, Ind.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>	

13a. FATHER'S NAME <b>Thomas McCaffrey</b>	13b. MOTHER'S MAIDEN NAME <b>Rose Martin</b>	14. NAME OF HUSBAND OR WIFE <b>Patrick Faherty</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT Address <b>Mrs. Alice McFarland, 1935 Forest Ave.</b>

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
IMMEDIATE CAUSE (a) <b>acute Coronary Occlusion</b>		<b>10 mins</b>
DUE TO (b) <b>Chr. Cardiac Vasculardisease</b>		<b>years.</b>
DUE TO (c) <b>420.1F</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). <b>fracture hip - fell at home apr 6, 1960</b>		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.) <b>FELL at Home</b>
20c. TIME OF INJURY Hour <b>10</b> - a.m. Month, Day, Year <b>Apr 6, 1960</b>		

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.) <b>Home</b>	20f. CITY, TOWN OR LOCATION <b>St Louis Mo</b>	COUNTY	STATE
21. I attended the deceased from <b>1954</b> to <b>May 9, 1960</b> and last saw her alive on <b>May 9, 1960</b> Death occurred at <b>7:30 pm</b> on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <b>Tom Shane M.D.</b>	(Degree or title)	22b. ADDRESS <b>4500 Olive St St Louis Mo</b>	22c. DATE SIGNED <b>5/10/60</b>
---	-------------------	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>May 12, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>
--	----------------------------------	---	---

24. FUNERAL DIRECTOR <b>Walter J. Donnelly</b>	ADDRESS <b>3840 Lindell Blvd.</b>	25. DATE RECD. BY LOCAL REG. <b>MAY 10 1960</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>
---	--------------------------------------	--	--

DOCUMENT

MEDICAL CERTIFICATION

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 W. A. Salter

Licensed Embalmer No. 4699

P. O. Address 3840 Lehigh

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.