

**JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**=60-021899**

FILED VS. MAY 31 1960 317

Primary Registration District No. 500

Registrar's No. 1659

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <b>ST LOUIS</b>				2. USUAL RESIDENCE (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>MONS.</b>		c. CITY OR TOWN <b>PINE LAWN</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>HILL TOP NURSING HOME 1301 S. FLORISSANT RD</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>4403 ROSEWOOD</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>MARY E, MADIGAN</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>23</b> Year <b>1960</b>					
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</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>5/24/1875</b>	9. AGE (last birthday) <b>84</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (City and state or country) <b>ST LOUIS MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>MICHAEL HICKEY</b>			13b. MOTHER'S MAIDEN NAME <b>MAY FINNEGAN</b>			14. NAME OF HUSBAND OR WIFE <b>JOHN J. MADIGAN</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>#</b>		17. INFORMANT Address <b>HELEN MADIGAN 4403 ROSEWOOD</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized arteriosclerosis</b>								INTERVAL BETWEEN ONSET AND DEATH <b>- 2</b>	
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.	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 <b>Dec 15 - 1959</b> to <b>May 23 - 1960</b> and last saw her <b>live</b> on <b>May 22 - 1960</b> Death occurred at <b>12:40 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <b>John G. Murney MD</b> (Degree or title)				22b. ADDRESS <b>5014 Shields Av</b>				22c. DATE SIGNED <b>5/23/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>5/25/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CALVARY CEMETERY</b>		23d. LOCATION (City, town, or county) <b>ST LOUIS MISSOURI</b> (State)				
24. FUNERAL DIRECTOR <b>STROOT - CARROLL 4600 NATURAL BRIDGE</b> ADDRESS			25. DATE RECD. BY LOCAL REG. <b>5-24-60</b>		26. REGISTRAR'S SIGNATURE <b>John G. Murney MD</b>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*no dissection  
Thekla*

**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 M W Rueter

Licensed Embalmer No. 4865

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.