

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED JUN 20 1960

-60-025274

INDEXED

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 1832

STATE FILE NUMBER

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>St. Louis</b>	b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Richmond Heights</b>	a. STATE <b>Mo.</b>	b. COUNTY <b>St. Louis</b>
Length of stay in 1b <b>10-wks.</b>		c. CITY OR TOWN <b>University City</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>St. Mary's Hospital</b>		d. STREET ADDRESS <b>6619 Kingsbury</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <b>Julia</b>	Middle	Last <b>Cowhey</b>	4. DATE OF DEATH	Month <b>June</b>	Day <b>11th.</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>3/18/1877</b>	9. AGE (last birthday) <b>83</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
---------------------	-------------------------------	---	--------------------------------------	-------------------------------------	-----------------------------------	---------------------------------

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>St. Louis, Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>
---	-----------------------------------	--	--

13a. FATHER'S NAME <b>John Kenneth</b>	13b. MOTHER'S MAIDEN NAME <b>Kate Rodden</b>	14. NAME OF HUSBAND OR WIFE <b>Cornelius Cowhey</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 <b>Mrs. Catherine Fusz, 320 Bristol Road, W.G.</b>	Address
---	--	---	---------

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 <b>16 days.</b>
IMMEDIATE CAUSE (a) <b>acute interstitial obstruction</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 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 5/25/60 to 6/11/60 and last saw her live on 6/11/60.  
Death occurred at 11:30 pm. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Paul Saell M.D.</b>	22b. ADDRESS <b>7820 Carondelet</b>	22c. DATE SIGNED <b>6/13/60</b>
--	--	------------------------------------

23a. BURIAL, CREMATION, or other disposition <b>REMOVAL</b>	23b. DATE <b>6/15/1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	23d. LOCATION (City, town, or county) <b>St. Louis, Missouri</b>
--	-------------------------------	---	---

24. FUNERAL DIRECTOR <b>Arthur J. Kennelly</b>	ADDRESS <b>3840 Lindell Blvd.</b>	25. DATE RECD. BY LOCAL REG. <b>6-14-60</b>	26. REGISTRAR'S SIGNATURE <b>June M. [Signature]</b>
---	--------------------------------------	--	---

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AUG 17 1960

**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 Francis Willio

Licensed Embalmer No. 3563  
P. O. Address 3840 L

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.