

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 23 1960

-60-032566

DED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **7366** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>ST. LOUIS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>ILL.</b> b. COUNTY <b>ST. CLAIR</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS</b>		Length of stay in 1b <b>6 DAYS</b>	c. CITY OR TOWN <b>O'FALLON</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>CARDINAL GLENNON Hosp</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>313 N. LINCOLN</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>-</b> Last <b>MAHONEY</b>			4. DATE OF DEATH Month <b>JULY</b> Day <b>24</b> Year <b>1960</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W -</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>JULY 18, 1960</b>	9. AGE (last birthday) <b>7-DAYS</b> IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HR: Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (City and state or country) <b>E. ST. LOUIS, ILL.</b>	
13a. FATHER'S NAME <b>JOSEPH MAHONEY</b>			13b. MOTHER'S MAIDEN NAME <b>BEVERLY MILLER</b>		14. NAME OF HUSBAND OR WIFE <b>-</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Joseph Mahoney</b> Address <b>313 N. Lincoln</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (b), (c), and (d). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Purpura, thrombocytopenic, congenital, at birth</b> <b>platelet antibodies</b>		INTERVAL BETWEEN ONSET AND DEATH. <b>at birth</b>
DUE TO (b) <b>platelet antibodies</b>		
DUE TO (c) <b>296X</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal cause of death. <b>hemorrhage of lungs &amp; kidneys</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input checked="" 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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 <b>N.L.</b>	COUNTY	STATE
---	--	--	---	--------	-------

21. I attended the deceased from **July 19 1960** to **July 24** and last saw <sup>her</sup>him alive on **July 23 1960**.  
Death occurred at **10 A** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>L. Lange M.D.</b> <i>L. Lange</i>	22b. ADDRESS <b>40 Church Belleville, Ill.</b> <i>40 Church Belleville Ill</i>	22c. DATE SIGNED <b>7-25-60</b>
---	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>JULY 25, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CALVARY CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>ST. LOUIS Mo.</b>
--	-----------------------------------	---	---

24. FUNERAL DIRECTOR <b>Walter Bauer</b> <i>Walter Bauer</i>	ADDRESS <b>1416 S. Taylor Ave.</b>	25. DATE RECD. BY LOCAL REG. <b>JUL 25 1960</b>	26. REGISTRAR'S SIGNATURE <b>Loard Smith. H.D.</b> <i>Loard Smith</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

*John Maher*

Licensed Embalmer No. <sup>#</sup>29-82

P. O. Address 648 N. 61<sup>st</sup>  
E. St. Louis

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.