

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH -60-039891

FILED VS OCT 26 1960

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10151 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b		c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Deaconess Hospital</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1342 Hughes Pl.</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>NETTIE</u> Middle <u>M.</u> Last <u>KEARNEY</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>18</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>5-2-1884</u>	9. AGE (last birthday) <u>76</u>	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) <u>Kitchen Employee-Pope Cafateria</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Warsaw, Poland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Kashmir Traczyk</u>			13b. MOTHER'S MAIDEN NAME <u>Antoinette Wojdyla</u>		14. NAME OF HUSBAND OR WIFE <u>Late William H. Kearney</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>499-28-7445</u>		17. INFORMANT Address <u>Joseph Kearney 1329 Hughes Pl.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) <u>Coronary Heart Disease</u> DUE TO (c) <u>Atherosclerosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4201</u> 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							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>1 wk</u> <u>Year</u>
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.) <u>4201</u>					
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 <u>Aug 1953</u> to <u>18 Oct-60</u> and last saw her <u>live</u> on <u>18 Oct-60</u> Death occurred at <u>2:10 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>George W. Zellgott M.D.</u>				22b. ADDRESS <u>4501 Manchester</u>		22c. DATE SIGNED <u>19 Oct-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Oct 21, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Resurrection Cemetery</u>		23d. LOCATION (City, town, or county) <u>St. Louis County, Mo.</u>		(State)	
24. FUNERAL DIRECTOR ADDRESS <u>Kriegshauser 4228 S. Kingshighway Blvd.</u>				25. DATE RECD. BY LOCAL REG. <u>OCT 19 1960</u>	26. REGISTRAR'S SIGNATURE <u>Loed Smith, M.D.</u>		

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 \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

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

Signed Edwin A. McArthur

Licensed Embalmer No. 2029

P. O. Address \_\_\_\_\_

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