MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-030939
STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7661

FILED AUG 23 1961

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St.Louis, Length of stay in 1b

c. CITY OR TOWN St.Louis, Inside Limits Yes ☐ No ☐

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4944 Beacon Ave. Inside Limits Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location) 4114a Hull Pl. Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First ROBERT Middle FRANCIS Last MAHONEY

4. DATE OF DEATH Month Aug. Day 15th, Year 1961

5. SEX Male

6. COLOR OR RACE White

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH 4-1-1898

9. AGE (last birthday) 63

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) Dept.Mgr.

10b. KIND OF BUSINESS OR INDUSTRY International Shoe

11. BIRTHPLACE (City and state or country) Rock Island, Ill.

12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME John Mahoney

13b. MOTHER'S MAIDEN NAME Sarah Monahan

14. NAME OF HUSBAND OR WIFE Bessie M.Mahoney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address Bessie M.Mahoney–4114a Hull Pl.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Metastatic Carcinoma - generalized

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Carcinoma of the lung

DUE TO (c) 163x

INTERVAL BETWEEN ONSET AND DEATH: 6 mos.

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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 May 5 1961, to Aug 15, 1961 and last saw her/him alive on Aug 14, 1961

Death occurred at 9:45 P.m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Henry E. Kattindelle M.D.

22b. ADDRESS 950 Francis Place St. Louis, Mo.

22c. DATE SIGNED 8/17/61

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE Aug.18,1961

23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery

23d. LOCATION (City, town, or county) St.Louis, (State) Mo.

24. FUNERAL DIRECTOR Kriegshauser ADDRESS 4228 S.Kingshighway

25. DATE RECD. BY LOCAL REG. AUG 17 1961

26. REGISTRAR'S SIGNATURE Earl Smith, M.D.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED

BY AFFIDAVIT OF DOCUMENT

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____ Signed _____
Signature of Student Embalmer

Licensed Embalmer No. 4533

P. O. Address _____

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.