

FILED APR 1 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10453**
2702
Registrar's No. _____

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN East St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital		d. STREET ADDRESS (If rural, give location) 579 N. 25th	

3. NAME OF DECEASED (Type or Print) Clementine Moynihan			4. DATE OF DEATH (Month) (Day) (Year) 3 24 49				
5. SEX F.	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 5-9-1867	9. AGE (In years last birthday) 61	IF UNDER 1 YEAR Days	IF UNDER 4 HRS. Hours	IF UNDER 15 MIN. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY?	

13a. FATHER'S NAME Edward Dierkes	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE --
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Jack Moynihan-579 N 25th St. E. St. Louis, Ill

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 27 hr
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Degenerative heart disease		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) in father DUE TO (c)		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes mellitus acute cholecystitis		260% 1 mo

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar 24, 1949, to Mar 24, 1949, that I last saw the deceased alive on Mar 24, 1949, and that death occurred at 2 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Kruszewski M.D.	23b. ADDRESS 3701 Grand St. E. St. Louis, Ill.	23c. DATE SIGNED 3-26-49
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 3-28-49	24c. NAME OF CEMETERY OR CREMATORY Mt Carmel
DATE REC'D BY LOCAL REG. 3-25-49		24d. LOCATION (City, town, or county) (State) Belleville, Ill.
REGISTRAR'S SIGNATURE J. B. Foster		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Neil Walsh Barnes- East St. Louis, Ill.

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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
Student Embalmer

Signed

Licensed Embalmer No.

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 this body is not embalmed, fact should be so stated above.