

FILED MAY 28 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17851

State File No. _____

BIRTH NO. _____		REG. DIST. NO. <u>312</u>		PRIMARY REG. DIST. NO. <u>3063</u>		Registrar's No. <u>1133</u>	
1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u> b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>CLAYTON</u>) c. LENGTH OF STAY (In this place) <u>3 DAYS</u> d. FULL NAME OF HOSPITAL OR INSTITUTION <u>COUNTY HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST. LOUIS</u> c. CITY (If outside corporate limits, write RURAL and give township) <u>JENNINGS</u> d. STREET ADDRESS (If rural, give location) <u>5546 JENNINGS ROAD.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>WILLIAM</u> b. (Middle) <u>J.</u> c. (Last) <u>CLOONEY</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>5/5/49</u>		5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>11/9/1873</u>		9. AGE (In years last birthday) <u>76</u>		IF UNDER 1 YEAR Month(s) Day(s) Hour(s) Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PLUMBER</u>		11. BIRTHPLACE (State or foreign country) <u>ST. LOUIS, MO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>WALTER CLOONEY</u>		13b. MOTHER'S MAIDEN NAME <u>BRIDGET BRIDARICK</u>		14. NAME OF HUSBAND OR WIFE <u>MARGARET CLOONEY</u>			
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.		17. INFORMANT'S SIGNATURE OR NAME <u>Margaret Clooney</u>			
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arterio sclerosis</u> ANTECEDENT CAUSES MORIBUND CONDITIONS, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>malnutrition</u> DUE TO (c) <u>dehydration</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Auricular Fibrillation</u>				INTERVAL BETWEEN ONSET AND DEATH <u>43:00</u> <u>9:00</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" 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)		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 <u>5-3-49</u> , 19 <u>49</u> , to <u>5-5-49</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>5-5-49</u> , 19 <u>49</u> , and that death occurred at <u>2:15 PM</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>John W. Jones M.D.</u>				23b. ADDRESS <u>601 Brentwood, Clayton, Mo.</u>		23c. DATE SIGNED <u>5-6-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>5/9/1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>ST. PETERS CEM.</u>		24d. LOCATION (City, town, or county) (State) <u>WELLSTON, ST. LOUIS CO, MO</u>	
DATE REC'D BY LOCAL REG. <u>5-8-49</u>		REGISTRAR'S SIGNATURE <u>John W. Jones M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Stock</u> ADDRESS <u>2117 E. Grand St. Louis</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

96
2
3

10
9
1

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 Frank A. Moore.....

Licensed Embalmer No. 3041.....

P. O. Address 2117 E Grand.....

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.