FILED SEP 20 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31675

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO 1003 Registrar's No. 7917

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) ST. LOUIS,
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3635 LEE AVE

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE MISSOURI
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) ST. LOUIS,
d. STREET ADDRESS (If rural, give location) 3635 LEE AVE

3. NAME OF DECEASED (Type or Print)
a. (First) VERONICA (VERA)
b. (Middle) R.
c. (Last) CLOONEY

4. DATE OF DEATH (Month) SEPT (Day) 12, (Year) 1949

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED
8. DATE OF BIRTH 2/16/ 1890
9. AGE (In years last birthday) 59 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours 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) BROOKLYN N. Y.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME JAMES GILLIGAN
13b. MOTHER'S MAIDEN NAME MARY GALLAGHER
14. NAME OF HUSBAND OR WIFE PATRICK A. CLOONEY

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. NONE
17. INFORMANT'S SIGNATURE OR NAME PATRICKSA. CLOONEY **ADDRESS** 3635 LEE AVE

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) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 12 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Hypertensive heart disease

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at 9 P. m., from the causes and on the date stated above.*

23a. SIGNATURE Henry C. Westermann (Degree or title) M.D.
23b. ADDRESS 2136 East Grand Ave
23c. DATE SIGNED SEP 12 1949

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
24b. DATE 9/14/49
24c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY
24d. LOCATION (City, town, or county) (State) ST. LOUIS, MISSOURI

DATE REC'D BY LOCAL REG. SEP 13 1949
REGISTRAR'S SIGNATURE J B Lasater
25. FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** STROOT - CARROLL 4600 NATURAL BRIDGE

(Licensed Embalmer's Statement on Reverse Side)

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 Ben Hoffman

Licensed Embalmer No. 4366

P. O. Address St Louis, M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl the above constitutes grounds for revocation of license.)

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