

FILED APR 12 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10091

State File No.

940
2

BIRTH NO. 124 REG. DIST. NO. 316 PRIMARY REG. DIST. NO. 6075 Registrar's No. 120

1. PLACE OF DEATH a. COUNTY <u>St. Francois</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR <u>Farmington</u> TOWN <u>RURAL St. Francois</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR <u>Webster Groves</u> TOWN <u>Webster Groves</u>	
c. LENGTH OF STAY (in this place) <u>33 Yrs; 3M; 23 Ds</u>		d. STREET ADDRESS (If rural, give location) <u>404 Greely</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Missouri State Hospital No. 4</u>			

3. NAME OF DECEASED a. (First) <u>JULIA</u> (Type or Print)		b. (Middle) <u>K.</u>		c. (Last) <u>ROONEY</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>March 21, 1950</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u>		8. DATE OF BIRTH <u>Sept. 6, 1864</u>	
9. AGE (In years last birthday) <u>85</u>		IF UNDER 1 YEAR Months <u>6</u> Days <u>15</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>		11. BIRTHPLACE (State or foreign country) <u>Cincinnati, Ohio</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			

13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE	
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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>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Records State Hospital No. 4, Farmington, Mo.</u>		ADDRESS	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bronchial Pneumonia - - - - -</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 das.</u>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Dementia Praecox Psychosis - - - - -</u>				At least <u>35 yrs.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Hospital Ward</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Farmington, St. Francois Mo.</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>March 3, 1950 Unk. m.</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Patient fell, fracturing her hip.</u>	

22. I hereby certify that I attended the deceased from March 3, 1950, to March 21, 1950, that I last saw the deceased alive on March 21, 1950, and that death occurred at 8:35 P. m., from the causes and on the date stated above.

23a. SIGNATURE <u>[Signature]</u> (Degree or title)		23b. ADDRESS <u>State Hospital No. 4, Farmington, Mo.</u>		23c. DATE SIGNED <u>3-23-50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>3-23-50</u>		24c. NAME OF CEMETERY OR CREMATION <u>Oak Hill Cemetery</u>	
				24d. LOCATION (City, town, or county) (State) <u>St. Louis County, Missouri</u>	

DATE REC'D BY LOCAL REG. <u>Apr. 1, 1950</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Parker Funeral Home, 15 W. Lockwood</u>		ADDRESS <u>Webster Groves, Mo.</u>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

APR 11 1950

DEPARTMENT OF HEALTH OFFICE No.

FILE No. 450-544

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 C. C. Aldrich

Licensed Embalmer No. 1332

P. O. Address Webster Groves

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.