

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29443**
REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **2711**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 2711	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY 2179			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS 0		c. LENGTH OF STAY (In this place) 12 DAYS		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS 0			
d. FULL NAME OF HOSPITAL OR INSTITUTION MISSOURI BAPTIST HOSPITAL				d. STREET ADDRESS (If rural, give location) 17 4015 SHAW AVE			
3. NAME OF DECEASED (Type or Print) a. (First) LILLIAN			b. (Middle) _____		c. (Last) FOGARTY		4. DATE OF DEATH (Month) (Day) (Year) Aug. 12, 1952
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED 2	8. DATE OF BIRTH Nov. 17, 1890		9. AGE (In years last birthday) 61	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 10 Hrs. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FOOD DISPENSER		10b. KIND OF BUSINESS OR INDUSTRY SMALL ARMS CAFETERIA		11. BIRTHPLACE (City and State or Foreign Country) OMAHA, NEBRASKA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13a. FATHER'S NAME JOSEPH MURPHY		13b. MOTHER'S MAIDEN NAME ANN O'HEARN		14. NAME OF HUSBAND OR WIFE FRANK FOGARTY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs Mary F Kondor 3975 Castleman			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Rheumatic heart Disease					INTERVAL BETWEEN ONSET AND DEATH ??
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Mitral Stenosis					25yrs
		DUE TO (c) Myocarditis					10yrs
		II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Aortic abdominal Thrombosis					
19a. DATE OF OPERATION 8-11-52		19b. MAJOR FINDINGS OF OPERATION aortic abdominal Thrombosis				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? 410X			
22. I hereby certify that I attended the deceased from Dec 14, 1951 , to Aug 12, 1952 , that I last saw the deceased alive on Aug 11, 1952 , and that death occurred at 10:25 A.M. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) D J Verda M.D.				23b. ADDRESS 4500 Olive		23c. DATE SIGNED 8-12-52	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE AUG. 14, 1952	24c. NAME OF CEMETERY OR CREMATORY CAHARY CEM		24d. LOCATION (City, town, or county) (State) ST. LOUIS, MO		
DATE RECD BY LOCAL _____		REGISTRAR'S SIGNATURE Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Robert L. + V. C. 1905 So. GRAND			

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

1270.

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. 4326

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.