

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3845

State File No.

FILED FEB 3 1953

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 0617

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2119	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's Hospital		d. STREET ADDRESS (If rural, give location) 3911 Maffitt	
3. NAME OF DECEASED (Type or Print) s. (First) Mary		b. (Middle) Ellen	c. (Last) Tierney
4. DATE OF DEATH (Month) (Day) (Year) Jan. 18, 1953			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH March 29, 1878
9. AGE (In years last birthday) 74		10. a. DURING OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10. b. KIND OF BUSINESS OR INDUSTRY At Home
11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME Mark Tierney		13b. MOTHER'S MAIDEN NAME Margaret McCauley	14. NAME OF HUSBAND OR WIFE None
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. NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Harry Ratican, 3911 Maffitt
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) Cerebral Thrombosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive cerebral vasculature disease DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Auricular fibrillation	
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)		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? 443X
22. I hereby certify that I attended the deceased from July 4, 1952 , to Jan 18, 1953 , that I last saw the deceased alive on Jan 17, 1953 , and that death occurred at 3:31 a.m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Arthur K. Finskel M.D.		23b. ADDRESS 18 S. Kingshighway	23c. DATE SIGNED Jan 19, 53
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 1-20-53	24c. NAME OF CEMETERY OR CREMATORY Calvary	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
DATE REC'D BY LOCAL REG. JAN 19 1953		REGISTRAR'S SIGNATURE J. Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Harrigan-Sheahan, 4700 Washington

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 John J. Starnes

Licensed Embalmer No. 4108

P. O. Address St. Louis MO

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.