

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No.

2698

FILED JUL 31 1953

318

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6444

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
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. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		2077	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4540 Carter Ave				d. STREET ADDRESS (If rural, give location) 4540 Carter			
3. NAME OF DECEASED (Type or Print) a. (First) Catherine		b. (Middle) Mary		c. (Last) Mohan		4. DATE OF DEATH (Month) (Day) (Year) June 26, 1953	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Nov. 15, 1884		9. AGE (In years last birthday) 68	IF UNDER 1 YEAR Month 7 Day 11	IF UNDER 24 Hrs. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) Ireland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME John McTigue		13b. MOTHER'S MAIDEN NAME Penelope Nalty		14. NAME OF HUSBAND OR WIFE Michael			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS James P. Mohan 4540 Carter			
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.		<p align="center">MEDICAL CERTIFICATION</p> I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c) Cardiac Decompensation				INTERVAL BETWEEN ONSET AND DEATH 1 day 2 hrs 3 hrs	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input 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 _____ 4201			
22. I hereby certify that I attended the deceased from 5/16, 1953 , to 6/26, 1953 , that I last saw the deceased alive on 6/26, 1953 , and that death occurred at 7:30P m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) M. J. Mosteckin M.D.				23b. ADDRESS 3903 Olive St		23c. DATE SIGNED 6-27-53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 6/30/53	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		
DATE REC'D BY LOCAL REG. JUN 29 1953		REGISTRAR'S SIGNATURE Carl Smith		GENERAL DIRECTOR'S SIGNATURE Stuart		ADDRESS 1225 Union	

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

Melvin F. Kemper

Licensed Embalmer No. *4052*

P. O. Address *3505 Oakdale*

St. Louis 20, 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.