

FILED FEB 8 - 1955 THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

 State File No. **43591**
 Registrar's No. **11490**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 11490	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Louis			
b. CITY (If outside corporate limits, write RURAL and give town or township) Town Saint Louis		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Johns Hospital				e. STREET ADDRESS (If rural, give location) 2233 Edmund			
3. NAME OF DECEASED (Type or Print) a. (First) Joseph Francis b. (Middle) _____ c. (Last) Gaffney			4. DATE OF DEATH (Month) Dec. (Day) 16, (Year) 1954				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH May 24, 1904	9. AGE (In years last birthday) 50	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) Utility Man		10b. KIND OF BUSINESS OR INDUSTRY Vestal Chemical Co.		11. BIRTHPLACE (City and State or Foreign Country) Saint Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME James Gaffney		13b. MOTHER'S MAIDEN NAME Eva Nuelle		14. NAME OF HUSBAND OR WIFE Jewel Gaffney			
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. 494-01-1807	17. INFORMANT'S SIGNATURE OR NAME Mrs. J. Gaffney, 2233 Edmund 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, asthma, 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 ANTECEDENT CAUSES 2 strokes & insufficiency of aortic valve Morbidity 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.				INTERVAL BETWEEN ONSET AND DEATH ?	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____			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"/>		21h. HOW DID INJURY OCCUR? 411X			
22. I hereby certify that I attended the deceased from Dec. 15, 1954 , to Dec. 16, 1954 , that I last saw the deceased alive on Dec. 15, 1954 , and that death occurred at 9:15 m., from the causes and on the date stated above.							
23a. SIGNATURE Joseph R. Muech (Degree or Title) M.D.			23b. ADDRESS Mr. Theistic Bldg.		23c. DATE SIGNED 12/17/54		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 12/20/54	24c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY		24d. LOCATION (City, town, or county) (State) ST. LOUIS - MO		
DATE REC'D BY LOCAL REG. DEC 17 1954		REGISTRAR'S SIGNATURE J. Carl Smith		25. FUNERAL DIRECTOR'S SIGNATURE CRAIG, 4700 Washington ADDRESS -8-			

(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.....
Signature of Student Embalmer

Signed *G. W. Wilkins*.....

Licensed Embalmer No. *357*.....

P. O. Address *St. Louis*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.