

FILED FEB 2 - 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **2893**
Registrar's No. **0181**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) 0		e. STREET ADDRESS (If rural, give location) 2149 5424 Tholozan Ave.	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Anthony Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) MAURICE b. (Middle) J. c. (Last) MULCAHY	4. DATE OF DEATH (Month) (Day) (Year) Jan. 7 1955
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 27, 1878	9. AGE (In years last birthday) 76	# UNDER 1 YEAR Months	# UNDER 1 HR. Hours	# MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector (Retired)	10b. KIND OF BUSINESS OR INDUSTRY St. Louis Police Dept.	11. BIRTHPLACE (City and State or Foreign Country) Ireland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Patrick Robert Mulcahy	13b. MOTHER'S MAIDEN NAME Margaret Woulfe	14. NAME OF HUSBAND OR WIFE Emma Mulcahy
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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) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Emma Mulcahy	ADDRESS 5424 Tholozan Ave.
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Failure		3 days
	ANTECEDENT CAUSES *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic Myocarditis DUE TO (c) Chronic Asthma		5 yrs 10 yrs
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **12-27**, 19**54**, to **1-7**, 19**55**, that I last saw the deceased alive on **1-6-55**, and that death occurred at **2:45 A** m., from the causes and on the date stated above.

23a. SIGNATURE [Signature] (Degree or title) M.D.	23b. ADDRESS 5417 So Grand Blvd	23c. DATE SIGNED 1-7-55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Jan. 10, 1955	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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DATE REC'D BY LOCAL REG. JAN 7 1955	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE [Signature]	ADDRESS Kriegshauser 4228 S. Kingshighway Bl.
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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 *William R. White*.....

Licensed Embalmer No. *428*

P. O. Address *428 So. Main*

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.