

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

144114

STATE FILE NUMBER

FILED MAY 6 - 1957

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

3786

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, give TOWNSHIP only) Inside Limits OR TOWN <u>St. Louis</u> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3225 N. Florissant Little Sisters of Poor 11 yrs</u> Length of stay in lb <u>20</u>				d. STREET ADDRESS (If outside, give location) <u>3225 N. Florissant</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ellen</u> Middle <u>Ahern</u> Last <u>Ahern</u>			4. DATE OF DEATH Month <u>April</u> Day <u>19</u> Year <u>1957</u>				
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 3, 1874</u>	
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <u>82</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>4</u> Day <u>16</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>	
13. FATHER'S NAME <u>Eugene Ahern</u>				14. MOTHER'S MAIDEN NAME <u>Mary O'Brien</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mae B. Finan, 4869 Carter Ave.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-sclerotic heart disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 1/2</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						DUE TO (b)	
						DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>	
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>420.0</u>				
20c. TIME OF INJURY <u>Noct</u> Hour <u></u> Month <u></u> Day <u></u> Year <u></u> a. m. <u></u>							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>Jan 12 1957</u> to <u>April 19, 1957</u> and last saw her/him alive on <u>April 19, 1957</u> Death occurred at <u>7:00 am</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Type or print) <u>Edward H. Flotte M.D.</u>				22b. ADDRESS <u>2435 N. Grand Blvd</u>		22c. DATE SIGNED <u>4-20-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>April 22, 1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u>	
24. FUNERAL DIRECTOR <u>Arthur J. Donnelly</u> ADDRESS <u>3840 Lindell Blvd.</u>				25. DATE RECD. BY LOCAL REG. <u>APR 22 '57</u>		26. REGISTRAR'S SIGNATURE <u>Carl Smith M.D.</u> <u>mdb</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

300
1-56 4

Securing the medical certificate. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

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 *Francis Williamson*.....

Licensed Embalmer No. *356*.....

P. O. Address *3840 Line*.....

**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.**