

Health, Welfare Public Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-012756  
STATE FILE NUMBER

FILED MAR 24 1958

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 797

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|   |                                  |  |   |   |   |
|---|----------------------------------|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>St. Louis</b>   |                                  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MO</b><br>b. COUNTY <b>St. Louis</b> |   |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Normandy</b>  |                                  | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   | c. CITY OR TOWN <b>UNKNOWN</b>  |   | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>              |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>O'Sullivan N. Home</b>  |                                  | Length of stay in 1b<br><b>UNKNOWN</b>   | d. STREET ADDRESS (If outside, give location)   |   | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                        |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>CARRIE</b> Middle <b>MOONEY</b> Last <b>MOONEY</b>   |                                  |  | 4. DATE OF DEATH<br>Month <b>2</b> Day <b>25</b> Year <b>58</b>   |   |   |
| 5. SEX<br><b>female</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Oct 30, 1886</b>   |   | 9. AGE (In years last birthday)<br><b>71</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>UNKNOWN</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>NONE</b>   | 11. BIRTHPLACE (City and state or country)<br><b>UNKNOWN 9</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |
| 13a. FATHER'S NAME<br><b>UNKNOWN</b>  |                                  | 13b. MOTHER'S MAIDEN NAME<br><b>UNKNOWN</b>  |   | 14. NAME OF HUSBAND OR WIFE<br><b>UNKNOWN</b>                 |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>NONE</b>   |   | 17. INFORMANT Address<br><b>O'Sullivan N. Home - Normandy</b> |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Parkinson's disease</b>   |                                  |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>unknown</b>  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Atherosclerosis</b>  |                                  |  |   |   | <b>unknown</b>  |
| DUE TO (c) <b>350X</b>  |                                  |  |   |   |   |
| 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?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT <input 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.)<br><b>2</b>   |   |   |   |
| 20c. TIME OF INJURY<br>Hour _____ a.m. _____ p.m.<br>Month, Day, Year _____   |                                  |  |   |   |   |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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 <b>Aug 6, 1954</b> to <b>Feb 25, 1958</b> and last saw her alive on <b>2/24/58</b><br>Death occurred at <b>8 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated. |                                  |  |   |   |   |
| 22a. SIGNATURE-<br><b>Lewis Littmann MD</b> (Degree or title)   |                                  | 22b. ADDRESS<br><b>8231 Clayton Rd (17)</b>  |   | 22c. DATE SIGNED<br><b>2/26/58</b> (State)                    |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Anatomical</b>  |                                  | 23b. DATE<br><b>2-27-58</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Anatomical Board</b> |   |
|   |                                  | 23d. LOCATION (City, town, or county)<br><b>St. Louis, Mo.</b>   |   |   |   |
| 24. FUNERAL DIRECTOR<br><b>Rowland-Aker Mortuary Service</b><br><b>1104 Monobester Ave.</b><br><b>St. Louis 10, Mo.</b>   |                                  |  | 25. DATE RECD. BY LOCAL REG.<br><b>3-19-58</b>  |   | 26. REGISTRAR'S SIGNATURE<br><b>Herbert P. Donohue MD</b>   |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *No Embalmer* .....  
*[Signature]*  
Licensed Embalmer No. ....  
P. O. Address .....

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.