

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-046344

STATE FILE NUMBER

FILED JAN 5 1959 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12233

Health, Welfare and Public Service  
300-1-56  
All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John Hospital		Length of stay in lb D.O.A. 20	3. STREET ADDRESS (If outside, give location) 6964 Arthur		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Joseph Peter Soraghan			4. DATE OF DEATH Month Day Year Dec. 16 1958		
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 22, 1907	9. AGE (In years last birthday) 51	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Director		10b. KIND OF BUSINESS OR INDUSTRY Civilian Defense	11. BIRTHPLACE (City and state or country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Dr. John T. Soraghan			14. MOTHER'S MAIDEN NAME Mollie Dunn		
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. 494-10-3970	17. INFORMANT Address Mrs. Lillian Soraghan, 6964 Arthur. St. Louis		
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>Coronary Thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Coronary Arteriosclerosis</u> DUE TO (c) <u>Coronary Thrombosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.1</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1. hr</u> <u>2 wks.</u> <u>18 mo.</u>
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.)		
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year					
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>May 9, 1958</u> to <u>Dec 16, 1958</u> and last saw <sup>her</sup> him alive on <u>Dec 2, 1958</u> . Death occurred at <u>Dec 16, 1958</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>John B Matthews MD</u>			22b. ADDRESS <u>3707 Watson Rd</u>		22c. DATE SIGNED <u>12-18-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-19-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u>	
24. FUNERAL HOME TO WHICH REFERRED <u>HOFFMEISTER COLONIAL MORTUARY</u> <u>626 1/2 CHIP-EWA STREET, ST. LOUIS, MO.</u>		25. DATE RECD. BY LOCAL REG. <u>DEC 18 '58</u>	26. REGISTRAR'S SIGNATURE <u>J. C. Smith MD</u>		

(Licensed Embalmer's Statement on Reverse Side)

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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.....  
*Linus C. Hoffman*

Licensed Embalmer No. 38

P. O. Address 7814 S.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.  
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.