

Health, Welfare, Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023666
STATE FILE NUMBER

FILED JUN 22 1959 Registration District No. 317 Primary Registration District No. 548 Registrar's No. 1562

1. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY NORMANDY	
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) WEBSTER GROVES		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN NORMANDY 180 Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION GREENWOOD HOME AND HOSPITAL		Length of stay in lb 3 DAYS	d. STREET ADDRESS (If outside, give location) 7445 MARILLAC DR. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) ROBERT E. FURLONG			4. DATE OF DEATH Month 6 - Day 6 - Year 1959		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-22-1896	9. AGE (In years last birthday) 62	IF UNDER 1 YEAR Months 11 Days 22
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ACCOUNTANT		10b. KIND OF BUSINESS OR INDUSTRY Central Hdqrs	11. BIRTHPLACE (City and state or country) MISSOURI	12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME Michael A. Furlong		13b. MOTHER'S MAIDEN NAME Mary Ellen Croak		14. NAME OF HUSBAND OR WIFE CECILE U. FURLONG	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 408 07 0608		17. INFORMANT Address CECILE U. FURLONG, 7445 MARILLAC DR.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction			INTERVAL BETWEEN ONSET AND DEATH 2 min 20 years over 20 years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) hypertension		
	DUE TO (c) generalized arteriosclerosis		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) chronic brain aneurysm			19. WAS AUTOPSY PERFORMED? 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.) —		
20c. TIME OF INJURY Hour — Month, Day, Year a.m. — p.m. —	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOSPITAL		
20e. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20f. CITY, TOWN, OR LOCATION COUNTY STATE WEBSTER GROVES - ST. LOUIS - MISSOURI		

21. I attended the deceased from **JUNE 4, 1959**, to **JUNE 6, 1959** and last saw **him** alive on **JUNE 6, 1959**
Death occurred at **8:00 P.** on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Deputy or title) Edie A. Schmitt, MD	22b. ADDRESS 1800 GRANT RD, WEBSTER GROVES	22c. DATE SIGNED 6-8-1959
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23a. DATE 6-9-1959	23b. NAME OF CEMETERY OR CREMATORY Calvary Cem	23c. LOCATION (City, town, or county) (State) St. Louis Mo.
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24. FUNERAL DIRECTOR Dreherman Harold 1905 Main	25. DATE RECD. BY LOCAL REG. 6-8-59	26. REGISTRAR'S SIGNATURE John P. Murphy, MD
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(Licensed Embalmer's Statement on Reverse Side)

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 *Warren A. Carr*

Licensed Embalmer No. *3534*

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.