

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-009321

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 580

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

14002
24000

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

FILED MAR 2 1962

1. PLACE OF DEATH
a. COUNTY ST. LOUIS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY ST. LOUIS

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN CLAYTON Length of stay in 1b 14 DAYS

c. CITY OR TOWN CLAYTON PARK Inside Limits Yes No

c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS COUNTY HOSP. Inside Limits Yes No d. STREET ADDRESS (If outside, give location) 212 SADONIA Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last Eleanor Elizabeth Mooney 4. DATE OF DEATH Month Day Year 2 - 17 - 62

5. SEX F 6. COLOR OR RACE W 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH 9-4-1885 9. AGE (last birthday) 76 IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE 10b. KIND OF BUSINESS OR INDUSTRY AT HOME 11. BIRTHPLACE (City and state or country) TENNESSEE 12. CITIZEN OF WHAT COUNTRY U.S.

13a. FATHER'S NAME WILLIAM PENN 13b. MOTHER'S MAIDEN NAME HULDA CANNON 14. NAME OF HUSBAND OR WIFE ROBERT

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. UNKNOWN 17. INFORMANT Address THELMA JOHNSON, 212 SADONIA

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral thrombosis
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral arteriosclerosis
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) Pneumonia
PART III. If deceased was female was there a pregnancy in last 90 days. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 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. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 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 2-3-62 to 2-17-62 and last saw her alive on 2-17-62
Death occurred 10:50 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Albert H. Hoppe MD 22b. ADDRESS 601 So. Brentwood Clayton 5, Mo. 22c. DATE SIGNED 2/18/62

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL 23b. DATE 2-18-62 23c. NAME OF CEMETERY OR CREMATORY CROCKET CHAPEL 23d. LOCATION (City, town, or county) (State) TIPTONVILLE, TENN.

24. FUNERAL DIRECTOR ADDRESS ALBERT H. HOPPE, INC., 4700 WASHINGTON 25. DATE RECD. BY LOCAL REG. 2-18-62 26. REGISTRAR'S SIGNATURE John B. Marjuly MD

USE BLACK INK OR TYPEWRITER RIBBON

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 _____

Harvey Kahler

Licensed Embalmer No. 4596

P. O. Address St Louis, Mo

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.