

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-049648

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 3167 Primary Registration District No. 500 Registrar's No. 3585

STATE FILE NUMBER

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Rev. 4/59

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

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MEDICAL CERTIFICATION

SHOULD READ

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|                                                                                                                                                                                                                                                                      |                                  |                                                                                                                                                             |                                                                                                                                                                      |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>ST. LOUIS</u>                                                                                                                                                                                                                      |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MO.</u> b. COUNTY                                      |                                                                                                                                                                      |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>JEFFERSON BARRACKS, MISSOURI</u>                                                                                                                                                             |                                  | c. CITY OR TOWN <u>ST. LOUIS</u>                                                                                                                            |                                                                                                                                                                      |
| Length of stay in lb <u>8 DAYS</u>                                                                                                                                                                                                                                   |                                  | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                                           |                                                                                                                                                                      |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>VETERANS ADMINISTRATION</u>                                                                                                                                                        |                                  | d. STREET ADDRESS (If outside, give location)<br><u>600 N. KINGSHIGHWAY</u>                                                                                 |                                                                                                                                                                      |
| Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                                                                                                                                                                   |                                  |                                                                                                                                                             |                                                                                                                                                                      |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><u>JOHN A. MOONEY</u>                                                                                                                                                                                    |                                  | 4. DATE OF DEATH<br>Month Day Year<br><u>12-7-62</u>                                                                                                        |                                                                                                                                                                      |
| 5. SEX<br><u>MALE</u>                                                                                                                                                                                                                                                | 6. COLOR OR RACE<br><u>WHITE</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>6-12-97</u>                                                                                                                                   |
| 9. AGE (last birthday)<br><u>65 YEARS</u>                                                                                                                                                                                                                            |                                  | IF UNDER 1 YEAR IF UNDER 24 HR<br>Months Days Hours Min.                                                                                                    |                                                                                                                                                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>RETIRED</u>                                                                                                                                                        |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>REAL ESTATE</u>                                                                                                     |                                                                                                                                                                      |
| 11. BIRTHPLACE (City and state or country)<br><u>ST. LOUIS, MO.</u>                                                                                                                                                                                                  |                                  | 12. CITIZEN OF WHAT COUNTRY<br><u>U.S.A.</u>                                                                                                                |                                                                                                                                                                      |
| 13a. FATHER'S NAME<br><u>JOHN MOONEY</u>                                                                                                                                                                                                                             |                                  | 13b. MOTHER'S MAIDEN NAME<br><u>SARAH CONNELLY</u>                                                                                                          |                                                                                                                                                                      |
| 14. NAME OF HUSBAND OR WIFE<br><u>ELEANOR MOONEY</u>                                                                                                                                                                                                                 |                                  |                                                                                                                                                             |                                                                                                                                                                      |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>YES WWI</u>                                                                                                                                           |                                  | 16. SOCIAL SECURITY NO. <u>INFORMANT</u><br><u>ELEANOR MOONEY (wife)</u><br>Address <u>600 N. Kingshighway, St. Louis, Mo.</u>                              |                                                                                                                                                                      |
| 18. CAUSE OF DEATH (Enter only one cause per line)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>RESPIRATOR INSUFFICIENCY</u>                                                                                                                            |                                  |                                                                                                                                                             | INTERVAL BETWEEN ONSET AND DEATH<br><u>24 HOURS</u>                                                                                                                  |
| DUE TO (b) <u>MULTIPLE PULMONARY EMBOLI</u>                                                                                                                                                                                                                          |                                  |                                                                                                                                                             | <u>24-48 HOURS</u>                                                                                                                                                   |
| DUE TO (c) _____                                                                                                                                                                                                                                                     |                                  |                                                                                                                                                             |                                                                                                                                                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>ARTERIOSCLEROSIS HEART DISEASE WITH PASSIVE CONGESTION AND PULMONARY EDEMA-METASTATIC TUMOR FRONTAL LOBES BRAIN BILATERALLY</u> |                                  |                                                                                                                                                             | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                    |                                  | 20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)                                                                 |                                                                                                                                                                      |
| 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 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>11-29-62</u> to <u>12-7-62</u><br>Death occurred at <u>8:00</u> Pm on the date stated above, and to the best of my knowledge, from the causes stated.                                                                            |                                  |                                                                                                                                                             |                                                                                                                                                                      |
| 22a. SIGNATURE (Degree or title)<br><u>John A. Murphy, M.D. VET. ADM. HOSP: JEFF. BRKS. 25. MO.</u>                                                                                                                                                                  |                                  | 22b. ADDRESS                                                                                                                                                |                                                                                                                                                                      |
| 22c. DATE SIGNED<br><u>12-8-62</u>                                                                                                                                                                                                                                   |                                  |                                                                                                                                                             |                                                                                                                                                                      |
| 23a. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                            |                                  | 23b. DATE<br><u>12/11/62</u>                                                                                                                                |                                                                                                                                                                      |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>National Cemetery</u>                                                                                                                                                                                                       |                                  | 23d. LOCATION (City, town, or county) (State)<br><u>Jefferson Barracks, Mo.</u>                                                                             |                                                                                                                                                                      |
| 24. FUNERAL DIRECTOR<br><u>Albert H. Hoppe, Inc., 4700 Washington Blvd.</u>                                                                                                                                                                                          |                                  | 25. DATE RECD. BY LOCAL REG.<br><u>12-10-62</u>                                                                                                             |                                                                                                                                                                      |
| 26. REGISTRAR'S SIGNATURE<br><u>John A. Murphy, M.D.</u>                                                                                                                                                                                                             |                                  |                                                                                                                                                             |                                                                                                                                                                      |

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 Jay W Wilkenson

Licensed Embalmer No. 3575

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.