

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

7861

State File No. ....

Registrar's No. 1969

FILED MAR 11 1953

318

1003

BIRTH NO. ....

REG. DIST. NO. ....

PRIMARY REG. DIST. NO. ....

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS</u>		c. LENGTH OF STAY (in this place) <u>2 WKS</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. JOHN'S HOSPITAL</u>		c. CITY OR TOWN <u>ST. LOUIS</u>	
e. STREET ADDRESS (If rural, give location) <u>23 615<sup>th</sup> LYNCH</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>ANN</u> b. (Middle) <u>—</u> c. (Last) <u>QUEENAN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>FEB 19 1953</u>	
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>SINGLE</u>		8. DATE OF BIRTH <u>DEC 13 1893</u>	
9. AGE (In years last birthday) <u>59</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MASSUSE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>THE BODY</u>	
11. BIRTHPLACE (City and State or Foreign Country) <u>MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>JAMES QUEENAN</u>		13b. MOTHER'S MAIDEN NAME <u>HELEN MC CAREN</u>	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>MARGARET KYBURZ 615<sup>th</sup> LYNCH.</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerosis</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Arteriosclerotic Cardiovascular Disease</u>	
INTERVAL BETWEEN ONSET AND DEATH <u>at least 6 mo.</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>201X</u>	
22. I hereby certify that I attended the deceased from <u>2 Feb, 1953</u> , to <u>19 Feb, 1953</u> , that I last saw the deceased alive on <u>18 Feb, 1953</u> , and that death occurred at <u>11:35 A.M.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>John A. McCann M.D.</u>		23b. ADDRESS <u>St. John's Hospital</u>	
23c. DATE SIGNED <u>20 Feb 53</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	
24b. DATE <u>FEB 21 1953</u>		24c. NAME OF CEMETERY OR CREMATORY <u>CALVARY CEMETERY</u>	
24d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MO.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Thomas Kuti 2906 Bravin</u>	
DATE REC'D BY LOCAL REG. <u>FEB 20 1953</u>		REGISTRAR'S SIGNATURE <u>Carl Smith M.D.</u>	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 *Leo J. Budde*  
Licensed Embalmer No. *398*  
P. O. Address *St. Louis*

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.