

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3526

State File No.

74155
FILED JAN 26 1954

BIRTH NO. REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 347 Registrar's No. 105

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY	
b. CITY OR TOWN <u>Highland Heights</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS</u> <u>2259</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>ST. MARY HOSPITAL</u>		d. STREET ADDRESS (If rural, give location) <u>813 Cole</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>MICHAEL</u> b. (Middle) <u>ANTHONY</u> c. (Last) <u>MCKINLEY</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>JAN. 12, 1954</u>		
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>NEVER MARRIED</u>	
8. DATE OF BIRTH <u>OCT. 3, 1953</u>			9. AGE (In years last birthday) <u>3</u> <u>9</u>		If under 1 year: Months Days Hours Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MINOR</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>ST. LOUIS, MISSOURI</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S. AMERICA</u>					

13a. FATHER'S NAME <u>FRANK MCKINLEY</u>		13b. MOTHER'S MAIDEN NAME <u>Marcella Leming</u>		14. NAME OF HUSBAND OR WIFE <u>NONE</u>	
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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>NO</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Frank M^c McKinley 813 Cole ST</u>	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
<p>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</p>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Malnutrition</u>			<u>three days</u>
		ANTECEDENT CAUSES			
		DUE TO (b) <u>Atresia of distal ileum</u> DUE TO (c) <u>leukemia multiple abdominal adhesions paralytic ileus</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					

19a. DATE OF OPERATION <u>3</u>		19b. MAJOR FINDINGS OF OPERATION <u>Ileal atresia</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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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)	
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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?	
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22. I hereby certify that I attended the deceased from Nov. 27, 1953, to Jan. 12, 1954, that I last saw the deceased alive on Jan. 12, 1954, and that death occurred at 12:52 P.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Salvatore N. Biggio, M.D.</u>		23b. ADDRESS <u>St. Mary Hosp., St. Louis, Mo</u>		23c. DATE SIGNED <u>Jan 13, 1954</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>Jan 13 54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>	
24d. LOCATION (City, town, or county) <u>St. Louis Mo</u>		24e. (State) <u>Mo</u>			

DATE REC'D BY LOCAL REG. <u>1/13/54</u>		REGISTRAR'S SIGNATURE <u>Herbert R. ...</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Bernard ... 1431 ...</u>	
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(Licensed Embalmer's Statement on Reverse Side)

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

not embalmed

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
Student Embalmer

Signed _____

Licensed Embalmer No. _____

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 this body is not embalmed, fact should be so stated above.