

FILED SEP 7 1956

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28349

State File No. _____

 BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **7249**

1. PLACE OF DEATH a. COUNTY _____			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) - a. STATE MISSOURI. - b. COUNTY ST. LOUIS		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SAINT LOUIS:		c. LENGTH OF STAY (in this place) 7 weeks	c. CITY OR TOWN KIRKWOOD		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION HAMILTON NURSEING HOME			e. STREET ADDRESS (If rural, give location) 420 PAR LANE AVENUE		
3. NAME OF DECEASED (Type or Print) a. (First) GENEVIEVE b. (Middle) MORRISSEY c. (Last) EVINS			4. DATE OF DEATH (Month) (Day) (Year) AUGUST 5 1956		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH August 12, 1890	9. AGE (In years last birthday) 65	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE	10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (City and State or Foreign Country) SAINT LOUIS, MISSOURI.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME JAMES E. MORRISSEY		13b. MOTHER'S MAIDEN NAME ELIZABETH O'BRIEN		14. NAME OF HUSBAND OR WIFE ALBERT Y. EVINS	
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. NONE	17. INFORMANT'S SIGNATURE OR NAME ADDRESS MRS. A. ROY ALLISON 7325 COLGATE AVE.		
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, asthma, etc. It means the disease, injury, or complication which caused death.	<p align="center">MEDICAL CERTIFICATION</p> I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive C.V. Disease DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Old Cerebral Thrombosis				INTERVAL BETWEEN ONSET AND DEATH 8 days ? -
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 443x		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 6-22, 1956 , to 8-5, 1956 , that I last saw the deceased alive on 8-4, 1956 , and that death occurred at 2:40 A.M. , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or Title) Joseph V. O'Donnell, M.D.			23b. ADDRESS 539 N² Grand, St. Louis, Mo.		23c. DATE SIGNED 8-6-56
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE AUG 7/56	24c. NAME OF CEMETERY OR CREMATORY OAK GROVE MAUSOLEUM	24d. LOCATION (City, town, or county) (State) SAINT LOUIS COUNTY, MISSOURI.		
DATE REC'D BY LOCAL REG. AUG 6 1956	REGISTRAR'S SIGNATURE Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C. R. LUPTON & SONS 7233 DELMAR BLVD.		

(Licensed Embalmer's Statement on Reverse Side)

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

Dec 3-4980.
11-3,

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 *Clarence H. Miller*

Licensed Embalmer No. *4011*

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.