

Health, Welfare, Public Service  
 300-56  
 Director, Calverton, etc. must use only standard nomenclature in item 18. No symptoms with an asterisk. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED AUG 26 1957

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

29378

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **7516**

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Missouri Baptist Hosp</b>			Length of stay in lb	d. STREET ADDRESS <b>3817 Lafayette</b>			(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle Last <b>Devine</b>				4. DATE OF DEATH Month <b>Aug</b> Day <b>10</b> Year <b>1957</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 14 1872</b>		9. AGE (In years last birthday) <b>85</b> IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fireman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>St. Louis Fire Dept</b>		11. BIRTHPLACE (City and state or country) <b>Ireland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Unknown Devine</b>				14. MOTHER'S MAIDEN NAME <b>Unknown Donohue</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Daughter</b> Address <b>Marie Devine 3817 Lafayette</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia due to hypostasis + general debility</b> DUE TO (b) <b>Chronic Bronchitis and Pulmonary Emphysema</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>5020 Generalized arteriosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 wks. 2 yrs.</b>		
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			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 <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			20g. COUNTY	20h. STATE
21. I attended the deceased from <b>6 AUG 57</b> to <b>10 AUG 57</b> and last saw <del>her</del> <sup>him</sup> alive on <b>10 AUG 57</b> Death occurred at <b>12:45 P</b> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>Richard Jones MD</b>				22b. ADDRESS <b>3720 Washington St. Louis Mo</b>		22c. DATE SIGNED <b>17 AUG 57</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Aug 13 57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis Mo</b>			
24. FUNERAL DIRECTOR <b>E. J. Schnur 3125 Lafayette</b>			25. DATE RECD. BY LOCAL REG. <b>AUG 12 57</b>		26. REGISTRAR'S SIGNATURE <b>J. Carl Smith MD</b> <i>mgs</i>			

(Licensed Embalmer's Statement on Reverse Side)

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 *Joseph B. Vollmer*

Licensed Embalmer No. 40

P. O. Address 325 Lafayette

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.