

FILED NOV 4 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER
37027

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 252

300
1-57

1. PLACE OF DEATH a. COUNTY Saint Charles		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Charles	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Saint Charles		c. CITY OR TOWN Ferncliff addition	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph's Hosp.		d. STREET ADDRESS (If outside, give location) # 4 Wayne Lane	

3. NAME OF DECEASED (Type or print) First Jeannette Middle Ellen Last Duffy			4. DATE OF DEATH Month Oct. Day 29 Year 1957		
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 28, 1957	9. AGE (In years last birthday) 0	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 23 Min. 40
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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 country) Saint Charles, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME James R. Duffy	13b. MOTHER'S MAIDEN NAME Suzanne Lee Nichols	14. NAME OF HUSBAND OR WIFE None
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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) NO	16. SOCIAL SECURITY NO. None	17. INFORMANT James R. Duffy, St. Charles, Mo.	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital Atelactasis		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs.
DUE TO (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) 7620		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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.)
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20c. TIME OF INJURY Hour o.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	COUNTY	STATE
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21. I attended the deceased from 10-28-57 to 10-29-57 and last saw her alive on 10-28-57 Death occurred at 3 45 AM on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE [Signature] (Degree or title)	22b. ADDRESS 1144 Main St. Charles Mo	22c. DATE SIGNED 10-29-57
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Oct. 29, 1957	23c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery	23d. LOCATION (City, town, or county) (State) Saint Charles, Mo.
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24. FUNERAL DIRECTOR [Signature] ADDRESS St. Charles, Mo.	25. DATE RECD. BY LOCAL REG. 10-29-57	26. REGISTRAR'S SIGNATURE [Signature]
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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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 *Frank R Amalony*

Licensed Embalmer No. *4832*

P. O. Address *St. Charles 7*

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.