Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 59-002836 2 658

FILED FEB 10 1959 Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS, MO. Inside Limits: Yes ☑ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: ST. LOUIS CITY HOSPITAL Length of stay in 1b: 1 WEEK

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI b. COUNTY:
c. CITY OR TOWN: St. Louis Inside Limits: Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location): 1112 North 8th Str. Reside on Farm: Yes ☐ No ☑

3. NAME OF DECEASED (Type or print): First: CHARLES Middle: JOSEPH Last: CORCORAN
4. DATE OF DEATH: Month: JAN. Day: 18 Year: 1959
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: OCTOBER 11, 1886
9. AGE (In years last birthday): 72 IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): General Clerk
10b. KIND OF BUSINESS OR INDUSTRY: Western Union
11. BIRTHPLACE (City and state or country): St. Louis, Missouri
12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME: JAMES W. CORCORAN
13b. MOTHER'S MAIDEN NAME: MARY O'BREIN
14. NAME OF HUSBAND OR WIFE: MARY C. BREITLING
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 499-03-3741
17. INFORMANT: Virginia Corcoran Address: 1112 No. 8th Str.

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Pancreas Head — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 157X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐ 1

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 1/12/59, to 1/18/59 and last saw her/him alive on 1/18/59
Death occurred at 2:45 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Robt. E. Stuffelbeam (Degree or title) M.D.
22b. ADDRESS: 1515 LAFAYETTE AV.
22c. DATE SIGNED: 1-19-59

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 1-21-59
23c. NAME OF CEMETERY OR CREMATORY: CALVARY Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis, MISSOURI
24. FUNERAL DIRECTOR: BEIDERWIEDEN F. H. Inc. ADDRESS: 1936 St. Louis Av.
25. DATE RECD. BY LOCAL REG.: JAN 20 '59
26. REGISTRAR'S SIGNATURE: J. Carl Smith MD MSB

(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 .....

Licensed Embalmer No. 4520

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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