

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

59-011590

STATE FILE NUMBER

Health, Welfare, Public Service

300 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MAR 19 1959 Registration District No. 317 Primary Registration District No. 541 Registrar's No. 636

1. PLACE OF DEATH a. COUNTY <b>ST LOUIS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>ST LOUIS</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN <b>CLAYTON</b> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>BRECKENRIDGE</b> Inside Limits <b>HILLS 4000</b> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) Length of stay in 1b HOSPITAL OR INSTITUTION <b>ST LOUIS Co Hospital D.P.A.</b>		d. STREET ADDRESS <b>9217 BRISTOL</b> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John</b> <sup>First</sup> <b>TIMOTHY</b> <sup>Middle</sup> <b>EGAN</b> <sup>Last</sup>		4. DATE OF DEATH <b>3-9-59</b> Month Day Year	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-12-59</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		9b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	9c. AGE (In years last birthday) <b>2</b> 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) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	10c. CITIZEN OF WHAT COUNTRY? <b>USA</b>
11. BIRTHPLACE (City, and state or country) <b>ST LOUIS MO</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JAMES FRANCIS EGAN</b>		14. MOTHER'S MAIDEN NAME <b>ROSEMARY KUREK</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. <b>NONE</b>	
17. INFORMANT <b>JAMES FRANCIS EGAN</b> Address <b>9217 BRISTOL</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>Interstitial Pneumonia</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } 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) _____			INTERVAL BETWEEN ONSET AND DEATH
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.) <b>5.25X</b>	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year			
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
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <b>8:38A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>John C. Murphy M.D.</b> (Date or title)		22b. ADDRESS <b>801 S. Brentwood Clayton, Mo.</b>	
22c. DATE SIGNED <b>3/18/59</b>			
23a. FUNERAL CREMATION <b>Burial</b>	23b. DATE <b>3-10-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CALVARY CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>ST LOUIS MO</b>
24. FUNERAL DIRECTOR <b>EARL HILLOMAN</b> ADDRESS <b>OVERLAND 14th</b>		25. DATE RECD. BY LOCAL REG. <b>3-10-59</b>	
		26. REGISTRAR'S SIGNATURE <b>John C. Murphy M.D.</b>	

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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 *E. M. Schlemmer*.....

Licensed Embalmer No. *350*.....

P. O. Address *Bedford*.....

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.