

Health, Welfare, Public Service, 00, 57, MEDICAL CERTIFICATION, USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE, All diseases in Part I must be causally related.

STANDARD CERTIFICATE OF DEATH

59-023707
STATE FILE NUMBER

FILED JUL 15 1959

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1718

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Normandy</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 4. c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Charles The 1st Nursing Home</u> Length of stay in 1b <u>1 Month</u> | | d. STREET ADDRESS (If outside, give location) <u>4111 McRee Ave.</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>JOHN F. CREED</u> | | 4. DATE OF DEATH Month <u>June</u> Day <u>25</u> Year <u>1959</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 31, 1900</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tax Agent-State of Missouri</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) <u>58</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____ |
| 11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>Michael Creed</u> | | 13b. MOTHER'S MAIDEN NAME <u>Hannah Toomey</u> | |
| 14. NAME OF HUSBAND OR WIFE ----- | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name of unknown) (If yes, give dates of service) <u>No</u> <u>None</u> | |
| 16. SOCIAL SECURITY NO. <u>333-03-0250</u> | | 17. INFORMANT <u>David M. Jacquin</u> Address <u>1819 Lawrence Av.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism - antedates</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>site of origin - probably pelvis</u> DUE TO (c) <u>465+</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>circosis of liver</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>terminal</u> | |
| 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 <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 <u>3/19/59</u> , to <u>6/24/59</u> and last saw her alive on <u>6/24/59</u> Death occurred at <u>3:00 A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | | 22a. SIGNATURE (Degree or title) <u>James J. Seelye MD</u> | |
| 22b. ADDRESS <u>16 Hampton Village Plaza</u> | | 22c. DATE SIGNED <u>6/25/59</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | | 23b. DATE <u>June 27, 1959</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u> | |
| 24. FUNERAL DIRECTOR <u>Kriegshauser</u> ADDRESS <u>4228 S. Kingshighway</u> | | 25. DATE RECD. BY LOCAL REG. <u>6-26-59</u> | |
| 26. REGISTRAR'S SIGNATURE <u>John E. Murphy MD</u> | | | |

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. A. Mc Dermott*

Licensed Embalmer No. *3024*
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.