

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-034689

FILED OCT 13 1959

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 2601

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Richmond Heights	Length of stay in 1b 6 days	c. CITY OR TOWN Overland	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2164 N. Warson Rd.
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First Middle Last Mary Ellen MacLeod			4. DATE OF DEATH Month Day Year September 30, 1959		
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11-19-73	9. AGE (last birthday) 85	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) St. Charles, Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME James Riley		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Hugh MacLeod	
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 Address Hugh MacLeod, 2164 N. Warson Rd.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Asotemia		7 weeks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Arterial nephrosclerosis? myocardial infarction	1 year +
	DUE TO (c) Generalized arterio sclerosis	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Chronic ulcers varicose leg ulcers		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" 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	COUNTY	STATE

21. I attended the deceased from 8-11-58 to 9-30-59 and last saw her/him alive on 9-30-59
Death occurred at 10:45 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>John A. Wright M.D.</i>	(Degree or title)	22b. ADDRESS 950 Francis Place	22c. DATE SIGNED 10-1-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10-3-1959	23c. NAME OF CEMETERY OR CREMATORY Lake Charles Park	23d. LOCATION (City, town, or county) (State) Normandy, Missouri
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24. FUNERAL DIRECTOR Baumann Bros. Inc. Overland, Mo.	ADDRESS 2504 Woodson Rd.	25. DATE RECD. BY LOCAL REG. 10-1-59	26. REGISTRAR'S SIGNATURE <i>John B. Murphy M.D.</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 David C. Gibe

Licensed Embalmer No. 3454

P. O. Address Parlan

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.