

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-003760

FILED VS FEB 10 1960

Primary Registration District No. \_\_\_\_\_

Registration No. **2**

**962**

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>ST. LOUIS</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY _____					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS</b>		Length of stay in 1b <b>14 Yrs.</b>		c. CITY OR TOWN <b>ST. LOUIS, 8</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. JOHN'S HOSPITAL</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>4057A OLIVE ST</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>BENJAMIN</b> Middle <b>R.</b> Last <b>McVEIGH</b>				4. DATE OF DEATH Month <b>1</b> Day <b>25</b> Year <b>60</b>					
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>2-28-99</b>	9. AGE (last birthday) <b>60</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Watchman St. Louis Craft</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (City and state or country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>Unknown</b>			13b. MOTHER'S MAIDEN NAME <b>Mary J. Frances</b>			14. NAME OF HUSBAND OR WIFE <b>LEONA C. McVEIGH</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>			16. SOCIAL SECURITY NO. <b>yes(Unk)</b>		17. INFORMANT Address <b>Leona McVeigh, 4057a Olive</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>PERITONITIS</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b>		
DUE TO (b) <b>RUPTURED DIVERTICULITIS OF COLON</b>									
DUE TO (c) <b>572.1</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>EMPHYSEMA, ASHD + COR PULMONALE</b>							PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
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.) <b>NEITHER</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 checked="" 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 <b>1-21-60</b> to <b>1-26-60</b> and last saw her/him alive on <b>1-25-60</b> Death occurred at <b>7:02 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <b>William F. Mallette M.D.</b>				22b. ADDRESS <b>St. Johns Hospital</b>			22c. DATE SIGNED <b>1-26-60</b>		
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Reburial</b>		23b. DATE <b>1/28/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Matthews Cemetery</b>		23d. LOCATION (City, town, or county) <b>St. Louis, Missouri</b>		(State) _____		
24. FUNERAL DIRECTOR ADDRESS <b>McLaughlin, 2301 Lafayette(4)</b>				25. DATE RECD. BY LOCAL REG. <b>JAN 27 1960</b>		26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>			

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 *J. R. Chapman*

Licensed Embalmer No. 455

P. O. Address St. Louis

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.