

U.S. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 15 1960

-60-003882

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 218

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. Louis</u>		Length of stay in 1b	c. CITY OR TOWN <u>ST. Louis</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>LITTLE FLOWER Home</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2206 S. SPRING</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>PANSIE</u> Middle <u>M. O'DONNELL</u> Last			4. DATE OF DEATH Month <u>JAN</u> Day <u>1</u> Year <u>1960</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5-11-1883</u>	9. AGE (last birthday) <u>76</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>MISSOURI</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>WILLIAM CLIFF</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>JOHN O'DONNELL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>494-34-2955</u>		17. INFORMANT Address <u>JOHN O'DONNELL 2206 S. SPRING</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>Bronchopneumonia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cardiac failure and Cerebrovascular accident</u>			<u>2 weeks from</u>
DUE TO (c) <u>Arteriosclerotic Cardiovascular disease</u>			<u>6 weeks</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>General debilities of age</u>		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 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.) <u>422.1</u>
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 <u>7/27/57</u> to <u>1/1/60</u> and last saw her alive on <u>12/29/59</u> Death occurred at <u>150th St</u> on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE (Degree, or title) <u>Leo L Shacker MD</u>		22b. ADDRESS <u>9 Concord Center Drive, St Louis 23</u>	22c. DATE SIGNED <u>1/2/60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>JAN 4, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>RESURRECTION CEM</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS CO Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Thomas Kute 2906 Shaw</u>		25. DATE RECD. BY LOCAL REG. <u>JAN 4 1960</u>	26. REGISTRAR'S SIGNATURE <u>Joan Smith, M.D.</u>

m.s.B

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1135-380

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *James C. White*

Licensed Embalmer No. 4347

P. O. Address 2906 St

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do 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.