

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-012414

FILED VS MAR 25 1960

2 3004

STATE FILE NUMBER

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

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY | |
| b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Length of stay in 1b | c. CITY OR TOWN St. Louis |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hospital | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 5747 Terry Ave. |
| | | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |

| | | | | | | |
|--|---------------------------|---|--|---|---------------------------------------|------------------------------|
| 3. NAME OF DECEASED (Type or print) First Middle Last Patrick Butler | | | 4. DATE OF DEATH Month Day Year March 14, 1960 | | | |
| 5. SEX Male | 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 7/23/88 | 9. AGE (last birthday) 71 | IF UNDER 1 YEAR Months 7 Days 21 | IF UNDER 24 HR Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumbers' Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) Ireland | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME Unknown | | 13b. MOTHER'S MAIDEN NAME Unknown | | 14. NAME OF HUSBAND OR WIFE Margaret | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 489-22-1872A | 17. INFORMANT Address Margaret Butler 5747 Terry | | | |

| | | |
|--|------------|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Rt Pneumonia Viral origin</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>3 wks</i> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) | |
| | DUE TO (c) | <i>492x</i> |

| | | | |
|---|--|--|--|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Aneurysm of Aortic Arch -</i> | | 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.) | |
| 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 *Feb 20 1960* to *Mar 14 1960* and last saw ^{her}him alive on *March 13 1960*
Death occurred at *1:40* *A* m on the date stated above, and to the best of my knowledge, from the causes stated.

| | | | |
|--|-------------------|--|------------------------------------|
| 22a. SIGNATURE <i>D. G. Lincum M.D.</i> | (Degree or title) | 22b. ADDRESS <i>4126 Shreve Ave</i> | 22c. DATE SIGNED <i>3/14/60</i> |
|--|-------------------|--|------------------------------------|

| | | | |
|--|-----------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 23b. DATE <i>3/17/60</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>Calvary Cemetery</i> | 23d. LOCATION (City, town, or county) <i>St. Louis, Mo.</i> |
|--|-----------------------------|---|--|

| | | | |
|--|----------------------------------|--|---|
| 24. FUNERAL DIRECTOR <i>Chas. F. Stuart</i> | ADDRESS <i>1225 Union Bl.</i> | 25. DATE RECD. BY LOCAL REG. <i>MAR 15 1960</i> | 26. REGISTRAR'S SIGNATURE <i>Carl Smith M.D.</i> |
|--|----------------------------------|--|---|

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 _____
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

John J. Haines

Licensed Embalmer No. 4108

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.