

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-012949

FILED VS APR 5 1960

2 3502

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,		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DEPAUL HOSPITAL			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 4214 LEXINGTON AVE		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First ROSALIE Middle MEEGAN Last				4. DATE OF DEATH Month MARCH Day 26, Year 1960									
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH MAY 16, 1896		9. AGE (last birthday) 63		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) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) ST LOUIS MISSOURI		12. CITIZEN OF WHAT COUNTRY U.S.A.					
13a. FATHER'S NAME JOHN BURKE				13b. MOTHER'S MAIDEN NAME MARY GALLAGHER				14. NAME OF HUSBAND OR WIFE					
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. DON'T KNOW		17. INFORMANT Address VIRGINIA JENNY HUGHES 3934 a LEXINGTON							
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>Art. sclerotic Heart Disease</i> <i>(Embolus)</i> DUE TO (b) DUE TO (c) <i>420.0</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Carbons of Amine</i>										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			
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 <i>Jan 1960</i> to <i>March 1960</i> and last saw her alive on <i>3/26/60</i> Death occurred at <i>10.15a</i> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <i>William O. Moore M.D.</i>						22b. ADDRESS <i>3625 Fairview</i>			22c. DATE SIGNED <i>3/28/60</i>				
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE <i>3/29/60</i>		23c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY			23d. LOCATION (City, town, or county) ST LOUIS MISSOURI			(State)			
24. FUNERAL DIRECTOR STROOT - CARROLL 4600 NATURAL BRIDGE				ADDRESS		25. DATE RECD. BY LOCAL REG. MAR 28 1960		26. REGISTRAR'S SIGNATURE <i>Loal Smith M.D.</i>					

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*Do not mention
Fair + Natl. Bridge
Je 12 3 53
Tul 3 pm*

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 M W Rueter

Licensed Embalmer No. 4865

P. O. Address St Louis Mo

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.