

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-020635

FILED VS MAY 23 1960

318

Primary Registration District No.

1003

Registrar's No.

4648

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Length of stay in 1b		c. CITY OR TOWN Mehlville		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Rt. 11 Box 307		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FLORENCE Middle L. Last BAGNALL			4. DATE OF DEATH Month MAY Day 1 Year 1960					
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 2-3-1900	9. AGE (last birthday) 60	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher- Hancock School			10b. KIND OF BUSINESS OR INDUSTRY School	11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME William Lesseig			13b. MOTHER'S MAIDEN NAME Catherine McCabe		14. NAME OF HUSBAND OR WIFE Leslie W. Bagnall			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no none		16. SOCIAL SECURITY NO. 493-10-6310		17. INFORMANT Address Leslie W. Bagnall Rt. 11 Box 307				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MESENTERIC THROMBOSIS						INTERVAL BETWEEN ONSET AND DEATH 15 DAYS		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) CYSTOADENOCARCINOMA OF OVARY						10 YEARS		
DUE TO (c) _____ 175.0								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					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 checked="" type="checkbox"/> NO <input 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 _____ 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 NOV. 9, 1950 to MAY 1, 1960 and last saw her/him alive on MAY 1, 1960 Death occurred at 2:45 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <i>C. Hamilton, M.D.</i>				22b. BARNES HOSPITAL			22c. DATE SIGNED 5/2/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 5-4-1960	23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.				
24. FUNERAL DIRECTOR ADDRESS Kriegshauser 4228 S. Kingshighway Blvd.		25. DATE RECD. BY LOCAL REG. MAY 2 1960		26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

771 42

JAN 20 1954

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 R. W. Storaund

Licensed Embalmer No. 4007

P. O. Address _____

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.