

DURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-028724

FILED VS AUG 10 1960

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7097

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)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 7 HRS	c. CITY OR TOWN Lemay
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Alexian Bros. Hospital		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 157 Lemay Gardens Drive
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print)	First Joseph	Middle M.	Last Quinn	4. DATE OF DEATH	Month July	Day 14	Year 1960
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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 9/21/1899	9. AGE (last birthday) 60	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Freight Solicitor	10b. KIND OF BUSINESS OR INDUSTRY Nighthawk Frt. Lines	11. BIRTHPLACE (City and state or country) Nashville, Tennessee	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME James M. Quinn	13b. MOTHER'S MAIDEN NAME Elizabeth Kelly	14. NAME OF HUSBAND OR WIFE Elizabeth Griff Quinn
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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. None	17. INFORMANT Elizabeth Quinn 157 Lemay Gardens Dr.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Acute Dilatation of Heart		5 min.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) chronic cardio vascular disease	Several years
	DUE TO (c) Chy. Bronchitis 422.1	Several yrs

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 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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	Month, Day, Year
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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
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21. I attended the deceased from **1956** to **7-14-60** and last saw him alive on **7/14/60**
Death occurred at **8:30 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Erwin S. Recelios</i> (Degree or title) 4th	22b. ADDRESS 752 Lemay Ferry Rd	22c. DATE SIGNED 7/15/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE July 18, 1960	23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery	23d. LOCATION (City, town, or county) (State) Lemay, Missouri
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24. FUNERAL DIRECTOR C. Hoffmeister Mortuaries 7814 So. Broadway St. Louis, Mo.	25. DATE RECD. BY LOCAL REG. JUL 15 1960	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i> m d c.
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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 Schenck

Licensed Embalmer No. 4194

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.