

FEDERAL BUREAU OF INVESTIGATION U.S. DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-029165

FILED VS AUG 8 1960

377

Primary Registration District No. 500

Registrar's No. 2148

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>ST LOUIS</u>			
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Normandy</u>		Length of stay in 1b	c. CITY OR TOWN <u>Pine Lawn</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Normandy Osteopathic Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3814 Manola</u>		
3. NAME OF DECEASED (Type or print) First <u>Stephanie</u> Middle <u>Maguire</u> Last			4. DATE OF DEATH Month <u>July</u> Day <u>17</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>April 26 1960</u>	9. AGE (last birthday) IF UNDER 1 YEAR Months <u>2</u> Days <u>21</u> IF UNDER 24 HR Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis Mo</u>		12. CITIZEN OF WHAT COUNTRY	
13a. FATHER'S NAME <u>Steve Fisher</u>		13b. MOTHER'S MAIDEN NAME <u>Roberta Vickers</u>		14. NAME OF HUSBAND OR WIFE <u>-----</u>		
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.	17. INFORMANT <u>NORMANDX HOSP. RECORDS.</u> Address			
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>Acute Pulmonary Insufficiency</u> DUE TO (b) <u>Interstitial Pneumonitis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c)					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)					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 <u> </u> Month, Day, Year <u> </u>	s.m. <u> </u>	p.m. <u> </u>				
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 _____ to _____ and last saw her/him alive on _____ Death occurred at <u>9:30A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <u>John C. Murphy MD Asst. Health Commissioner</u>			22b. ADDRESS <u>801 S. Brentwood Clayton, Mo.</u>		22c. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>July 19, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis Mo</u>		
24. FUNERAL DIRECTOR <u>Miceli & Sons Funeral 1150 N. Kingshighway</u>		ADDRESS	25. DATE RECD. BY LOCAL REG. <u>7-18-60</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>		

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.