

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-029197

FILED VS. JUL 22 1960 317

Registration District No. Primary Registration District No. 590 Registrar's No. 2111 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY St. Louis				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo COUNTY St. Louis			
b. CITY (If outside corporate limits, give TOWNSHIP only) Wellston		Length of stay in 1b 3 1/2 Months		c. CITY OR TOWN Wellston		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Rockwood Manor Nursing Home			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Rockwood Manor Nursing Home		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Barbara Middle Crouther Last O'Connor				4. DATE OF DEATH Month July Day 12 Year 1960			
5. SEX F	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 8/15/1871	9. AGE (last birthday) 88	If UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	If UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (City and state or country) St. Louis, Mo		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Charles Crouther			13b. MOTHER'S MAIDEN NAME Unknown			14. NAME OF HUSBAND OR WIFE James J O'Connor	
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 Address St. Louis 33, Mo Mrs. Robert J O'Connor 6523 Julian			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic Cardio-vascular disease Chronic Brain Syndrome Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 year	
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	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> None			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. 7-6-60	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 7-6-60 to 7-12-60 and last saw her alive on 7-6-60 Death occurred at 6:40 pm 7-12-60 on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Allen M. Kearney, M.D.				22b. ADDRESS 4308 E. Peter of Louis		22c. DATE SIGNED 7-13-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE July 15, 1960	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or county) St. Louis, Mo.			
24. FUNERAL DIRECTOR Alexander & Sons 6175 Delmar Blvd				25. DATE RECD. BY LOCAL REG. 7-15-60		26. REGISTRAR'S SIGNATURE John E. [Signature]	

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 Joseph E. McCulloch

Licensed Embalmer No. 276

P. O. Address 16775 PCH

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.