

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-032551

FILED VS AUG 22 1960

318 Primary Registration District No. 1003 Registrar's No. 7328

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> b. COUNTY <u>St. Louis</u> | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u> | | | Length of stay in 1b | | c. CITY OR TOWN <u>St. Louis</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>Apt 201 4461 Olive St.</u> | | | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>Apt. 201 4461 Olive St.</u> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>LILLIE MAY McDERMOTT</u> | | | | 4. DATE OF DEATH Month Day Year <u>July 21, 1960</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>white</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Jan. 10 1886</u> | 9. AGE (last birthday) <u>74</u> | | IF UNDER 1 YEAR Months <u>6</u> Days <u>11</u> Hours <u></u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u> | | 11. BIRTHPLACE (City and state or country) <u>Audran Co., Mo</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> |
| 13a. FATHER'S NAME <u>Randolph Hammett</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Catherine Moran</u> | | | 14. NAME OF HUSBAND OR WIFE <u>Mrs. Mary Clayton, St. Louis, Mo</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> | | | 16. SOCIAL SECURITY NO. <u>none</u> | | 17. INFORMANT Address <u>1143 Howell St. St. Louis, Mo</u> | | |
| 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>Coronary Occlusion</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u> | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral vascular accidents with aphasia</u> <u>4 1/2 yrs</u> | | | | | | | |
| DUE TO (c) <u>Arteriosclerotic Hypertensive Heart Disease</u> <u>years</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4280</u> | | | | | | 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.) <u>4280</u> | | | |
| 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 <u>Jan. 7, 1953</u> to <u>July 21, 1960</u> and last saw her ^{her} _{him} alive on <u>July 21, 1960</u> Death occurred at <u>10:45 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>Joe. M. Orenstein, M.D.</u> | | | | 22b. ADDRESS <u>4500 Olive St</u> | | | 22c. DATE SIGNED <u>7/22/60</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>July 25, 1960</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Wellsville</u> | | 23d. LOCATION (City, town, or county) (State) <u>Wellsville Missouri</u> | | |
| 24. FUNERAL DIRECTOR <u>Wells Funeral Home, Wellsville, Mo</u> | | | | 25. DATE RECD. BY LOCAL REG. <u>JUL 22 1960</u> | | 26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u> | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS AUG 22 1960

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 _____

Howard F. Myer

Licensed Embalmer No. 1494

P. O. Address Wellesville, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.