

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-036760

FILED VS SEP 10 1960 317 Primary Registration District No. 531 Registrar's No. 2779 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN University City	Length of stay in lb. YRS -	c. CITY OR TOWN University City	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 6628 Crest	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 6628 Crest	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) EFFIE CHRONISTER	First Middle Last	4. DATE OF DEATH Sept. 13, 1960	Month Day Year
--	-------------------	---	----------------

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 12/12/96	9. AGE (last birthday) 63	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
-------------------------	----------------------------------	---	-------------------------------------	-------------------------------------	--------------------------------	------------------------------

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) Unk. Missouri	12. CITIZEN OF WHAT COUNTRY USA
---	--	--	---

13a. FATHER'S NAME Joseph McCormick	13b. MOTHER'S MAIDEN NAME Greenville McGregor	14. NAME OF HUSBAND OR WIFE Taz Chronister
---	---	--

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. Unknown	17. INFORMANT Taz Chronister, 6628 Crest, U.C., Mo.	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) Cerebral vascular accident		INTERVAL BETWEEN ONSET AND DEATH 2 wks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Arteriosclerosis, generalized 10-15 yrs.	
DUE TO (c)		

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 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.)
--	---	--

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 **May 1958** to **Sept 1960** and last saw her alive on **Sept 8, 1960**
Death occurred at **9-13-60 2:25 AM** on the date stated above, and to the best of my knowledge from the causes stated.

22a. SIGNATURE (Degree or title) Leonard J. Piccine M.D.	22b. ADDRESS 6303 Natural Bridge Mo	22c. DATE SIGNED 9-13-60
--	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 9/15/60	23c. NAME OF CEMETERY OR CREMATORY McGee Chapel Cemetery	23d. LOCATION (City, town, or county) (State) Glen Allen, Missouri
---	-----------------------------	--	--

24. FUNERAL DIRECTOR McLaughlin, 2301 Lafayette	ADDRESS (4)	25. DATE RECD. BY LOCAL REG. 9-14-60	26. REGISTRAR'S SIGNATURE John C. Murphy M.D.
---	-----------------------	--	---

DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

DR. PIERCIONE
6302 NATURAL BRIDGE
6:30-8 P.M. TUESDAY

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. 483

P. O. Address St. J.

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