

1. PLACE OF DEATH a. COUNTY Mo			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Louis Mo		Length of stay: 1b 3-days	c. CITY OR TOWN St Louis Mo		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION De Paul Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5705 Devonshire Ave		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Cecelia Middle A Last Delaney			4. DATE OF DEATH Month 10 Day 16 Year 60		
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6-19-1867	9. AGE (last birthday) 93	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Never Work		11. BIRTHPLACE (City and state or country) St Louis Mo	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME James Delaney		13b. MOTHER'S MAIDEN NAME Ellen Fitzgerald	
14. NAME OF HUSBAND OR WIFE Single		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. None	
17. INFORMANT Mrs Daniel Driscoll		Address 5705 Devonshire Ave			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) *Obstruction of sigmoid colon.*
 DUE TO (b) *Tubercles of sigmoid colon*
 DUE TO (c) *570.3*
 INTERVAL BETWEEN ONSET AND DEATH
2 wks.
2 weeks.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
Arteriosclerosis heart disease

PART III. If deceased was female was there a pregnancy in last 90 days.
 Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO

20a. ACCIDENT SUICIDE HOMICIDE

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 NOT WHILE AT WORK

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 *October 8, 1960* to *October 16, 1960* and last saw ^{her}/_{him} alive on *October 16, 1960*
 Death occurred at *3:30* a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)
John T. Santoro, M.D.

22b. ADDRESS
634 N. Grand Blvd.

22c. DATE SIGNED
Oct. 17, 1960

23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial

23b. DATE
10-18-1960

23c. NAME OF CEMETERY OR CREMATORY
Calvary Cemetery

23d. LOCATION (City, town, or county) (State)
St Louis Mo

24. FUNERAL DIRECTOR ADDRESS
Arthur J. Donnelly **3840 Lindell Blvd**

25. DATE RECD. BY LOCAL REG.
OCT 17 1960

26. REGISTRAR'S SIGNATURE
Donald Smith M.D.

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 _____, Student Embalmer No. _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed James William

Licensed Embalmer No. 356

P. O. Address 3840

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