

DI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 1 4 1960

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11605

-60-043418

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY St. Louis			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) ST. LOUIS, MO.		Length of stay in 1b Life	c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP# 1			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1112 No. Ninth St	
3. NAME OF DECEASED (Type or print) First EMILY Middle _____ Last BYRNES			4. DATE OF DEATH Month NOVEMBER Day 30 Year 1960		
5. SEX F.	6. COLOR OR RACE W.	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5/6 1877	9. AGE (last birthday) 83	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (City and state or country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Dennis Byrnes		13b. MOTHER'S MAIDEN NAME Catherne Murry		14. NAME OF HUSBAND OR WIFE None	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. None	17. INFORMANT Agnes Byrnes Address 1112 No Ninth St		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Peripartur Vascular Collapse**

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) **Arteriosclerotic Heart disease**

DUE TO (c) **4200**

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.
 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 **11-25-60** to **11-30-60** and last saw her/him alive on **11-30-60**
 Death occurred at **9:10 P** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)
Franis Carey MD

22b. ADDRESS
1515 LAFAYETTE AVE.

22c. DATE SIGNED
11-30-60

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

23b. DATE
Dec. 3, 1960

23c. NAME OF CEMETERY OR CREMATORY
Calvary

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

23e. STATE
Mo.

24. FUNERAL DIRECTOR
Arthur [Signature] ADDRESS **3810 Lindell Blvd**

25. DATE RECD. BY LOCAL REG.
DEC 2 1960

26. REGISTRAR'S SIGNATURE
Coal 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
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed 

Licensed Embalmer No. 4619

P. O. Address 3830

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.