

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-50-044470

FILED VS NOV 28 1960

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 3401

STATE FILE NUMBER

DED

12/2/60

Dec. 14, 1960

Dec. 14, 1960

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DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF Funeral Director

1. PLACE OF DEATH a. COUNTY <u>St Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>St Louis</u>						
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirkwood</u>		Length of stay in 1b <u>8 YRS</u>		c. CITY OR TOWN <u>Kirkwood -</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>370 Nelda Ave</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>370 Nelda</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>JANE</u> Last <u>QUINN</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>22</u> Year <u>1960</u>						
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>12/4/20</u>		9. AGE (last birthday) <u>40</u>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		
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>HOME</u>		11. BIRTHPLACE (City and state or country) <u>St Louis</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13a. FATHER'S NAME <u>EDMUND WILDERMUTH</u>			13b. MOTHER'S MAIDEN NAME <u>Ada Hawkins</u>			14. NAME OF HUSBAND OR WIFE <u>Leo J. Quinn</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>72070</u>		17. INFORMANT <u>Leo J. Quinn</u>			Address <u>Kirkwood</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>Cardiac Failure</u>								INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Carcinoma of lung &amp; mediastinum</u>								1 year		
DUE TO (c) <u>Cerebral metastasis</u>										
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 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 <u>Dec. 1959</u> to <u>Nov 22 60</u> and last saw her <u>him</u> alive on <u>Nov. 17, 1960</u> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE (Degree or title) <u>Phillip Comens MD</u>				22b. ADDRESS <u>6500 Chippewa</u>				22c. DATE SIGNED <u>11/22/60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial 11-25-60</u>		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY <u>RESURRECTION</u>		23d. LOCATION (City, town, or county) (State) <u>St Louis Missouri</u>				
24. FUNERAL DIRECTOR <u>John J. Starnes</u>				25. DATE RECD. BY LOCAL REG. <u>11-23-60</u>		26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>				

VS DEC 2 1960 SA

**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. \_\_\_\_\_  
P.O. Address \_\_\_\_\_

**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.