

**JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**=60-044545**

**FILED VS DEC 12 1960**

**317**

Primary Registration District No. **541**

Registrar's No. **3505**

STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <b>St. Louis</b>			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Clayton</b>		Length of stay in 1b <b>3 days</b>	c. CITY OR TOWN <b>Lemay</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis County Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>329 Flacid ave.</b>		
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Florence</b> Middle <b>M.</b> Last <b>Smith</b>			<b>4. DATE OF DEATH</b> Month <b>Dec</b> Day <b>1</b> Year <b>1960</b>			
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>11-27-1889</b>	<b>9. AGE (last birthday)</b> <b>71</b>	IF UNDER 1 YEAR Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own Home</b>	<b>11. BIRTHPLACE</b> (City and state or country) <b>St. Louis, Mo.</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>USA</b>	
<b>13a. FATHER'S NAME</b> <b>Geo. W. McQuillen</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Eleanor Byrnd</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>Frank J.</b>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>	<b>17. INFORMANT</b> Address <b>Edna Ellman 3531 Manhattan</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral pulmonary embolism</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Generalized arteriosclerosis</b> DUE TO (c)					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. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)				
<b>20c. TIME OF INJURY</b> Hour Month, Day, Year a.m. p.m.	<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>					
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		<b>COUNTY</b> <b>STATE</b>		
<b>21. I attended the deceased from</b> <b>11-28-60</b> to <b>12-1-60</b> and last saw her <sup>him</sup> alive on <b>12-1-60</b> Death occurred at <b>10:50 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.						
<b>22a. SIGNATURE</b> (Degree or title) <b>Robert Gronowicz M.D.</b>			<b>22b. ADDRESS</b> <b>601 S. Brentwood Clayton, Mo.</b>		<b>22c. DATE SIGNED</b> <b>12/1/60</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>	<b>23b. DATE</b> <b>12-5-1960</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>National Cemetery</b>	<b>23d. LOCATION</b> (City, town, or county) (State) <b>Jefferson Bks. Mo.</b>			
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>C. Hoffmeister Mortuaries</b> <b>7814 S. Broadway</b>		<b>25. DATE RECD. BY LOCAL REG.</b> <b>12-2-60</b>	<b>26. REGISTRAR'S SIGNATURE</b> <b>John B. Murphy M.D.</b>			

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 me

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*John L. Dennis*

Licensed Embalmer No. 4194

P. O. Address St. Louis

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.