

DED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN Pine Lawn	
Length of stay in lb		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DePaul Hospital		d. STREET ADDRESS (If outside, give location) 4195 Beachwood	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First **Eugene** Middle **P.** Last **Toolen** 4. DATE OF DEATH Month **Dec.** Day **11,** Year **1960**

5. SEX Male	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 11/11/78	9. AGE (last birthday) 82	IF UNDER 1 YEAR Months 1 Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor	10b. KIND OF BUSINESS OR INDUSTRY Toolen Const. Co.	11. BIRTHPLACE (City and state or country) Ireland	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Owen Toolen	13b. MOTHER'S MAIDEN NAME Margaret Hunt	14. NAME OF HUSBAND OR WIFE Mary
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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. 478383728	17. INFORMANT Francis X. Toolen	Address 4500 Begg
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Total Vein Thromboses DUE TO (b) Cirrhosis of Liver DUE TO (c) 581.0		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 type="checkbox"/> N- <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.)
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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
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21. I attended the deceased from **April 1957** to **12/11/60** and last saw ^{her}him alive on **12/11/60**
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Robert F. Tolshread M.D. (Degree or title)	22b. ADDRESS 3720 Washington	22c. DATE SIGNED 12/13/60 (State)
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23b. BURIAL, CREMATION, REMOVAL (Specify) Burial	23c. DATE 12/15/60	23d. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23e. LOCATION (City, town, or county) St. Louis, Mo.
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24. FUNERAL DIRECTOR Chas. F. Stuart	ADDRESS 1225 Union	25. DATE RECD. BY LOCAL REG. DEC 14 1960	26. REGISTRAR'S SIGNATURE Loan Smith M.D.
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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 _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Elton R. Remelick

Licensed Embalmer No. 428

P. O. Address St. Louis

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.