

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 25 1961

318

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342

61-003497
STATE FILE NUMBER

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

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 10 days		c. CITY OR TOWN Clayton		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Firmin Desloge Hosp.			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 225 N. Meramec Ave.		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MABEL Middle MARGARET Last O'DONNELL				4. DATE OF DEATH Month Jan. Day 10 Year 1961				
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 1/13/1894	9. AGE (last birthday) 66	IF UNDER 1 YEAR Months 11 Days 27	IF UNDER 24 HR Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Claim adjuster		10b. KIND OF BUSINESS OR INDUSTRY S.S. Administration		11. BIRTHPLACE (City and state or country) Windsor Spgs. Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME Cornelius C. O'Donnell			13b. MOTHER'S MAIDEN NAME Mabel Wells			14. NAME OF HUSBAND OR WIFE -----		
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. -----		17. INFORMANT Address Hazel Rehagen 940 St. Patrice			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Metastatic Carcinoma (Adeno) DUE TO (b) Adeno Carcinoma of left ovary DUE TO (c) 175.0							INTERVAL BETWEEN ONSET AND DEATH 6 Months impmo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) arteriosclerosis and Hypertension						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		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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.) St Louis		20f. CITY, TOWN, OR LOCATION St Louis		COUNTY Mo STATE Mo		
21. I attended the deceased from 10-3-35 to 1/10/61 and last saw her/him alive on 1/10/61 Death occurred at 1/10/61 430 A m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE May Stapleff M.D. (Degree or title)				22b. ADDRESS 512 Doree Place		22c. DATE SIGNED 1/11/61		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Jan. 13, 1961	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis, Mo.				
24. FUNERAL DIRECTOR ADDRESS A.H. Bocklage 6536 Clayton Rd.				25. DATE RECD. BY LOCAL REG. JAN 12 1961		26. REGISTRAR'S SIGNATURE Loal Smith M.D.		

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 Stanley H. Dixon

Licensed Embalmer No. 4193

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.