

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 30 1961

317

500 590

238

-61-003949

STATE FILE NUMBER

AMENDED

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

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY St. Louis | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Florissant | | Length of stay in lb 4 1/2 years | | c. CITY OR TOWN Florissant | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2465 St. Catherine Lane | | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 2465 St. Catherine Lane | |
| 3. NAME OF DECEASED (Type or print) First ANNA Middle CAREY Last CAREY | | | | 4. DATE OF DEATH Month January Day 21 Year 1961 | | | |
| 5. SEX female | | 6. COLOR OR RACE white | | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 1/26/1875 | |
| 9. AGE (last birthday) 85 years | | IF UNDER 1 YEAR Months _____ Days _____ | | IF UNDER 24 HR Hours _____ Min. _____ | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) St. Louis, Missouri | |
| 12. CITIZEN OF WHAT COUNTRY U. S. A. | | | | 13a. FATHER'S NAME David Carey | | | |
| 13b. MOTHER'S MAIDEN NAME Not Known | | | | 14. NAME OF HUSBAND OR WIFE Thomas F. Carey | | | |
| 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 Marie Lueke - 2465 St. Catherine | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thromboses Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerosis DUE TO (c) _____ 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 | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 days 4 yrs | |
| 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 5-1-57 to 1-21-61 and last saw her ^{her} alive on 1-15-61 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE Chris. Jost M.D. (Degree or title) | | | | 22b. ADDRESS 6000 W. Florissant | | 22c. DATE SIGNED _____ | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) removal | | 23b. DATE Jan 25, 1961 | | 23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | | 23d. LOCATION (City, town, or county) (State) St. Louis Missouri | |
| 24. FUNERAL DIRECTOR BUCHHOLZ MORTUARY-5967 W. Florissant Ave. | | | | 25. DATE RECD. BY LOCAL REG. 1-24-61 | | 26. REGISTRAR'S SIGNATURE John B. Murphy 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 Ralph E. Lindner

Licensed Embalmer No. 4275

P. O. Address St. Louis, Mo.

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.