

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 30 1961

-61-003993

STATE FILE NUMBER

AMENDED

Registration District No. 317 Primary Registration District No. 546 Registrar's No. 152

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>Overland</u>		Length of stay in 1b <u>50 yrs</u>	c. CITY OR TOWN <u>8920 Lackland Overland</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>2200 N Lindberg</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>8920 Lackland</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Theresa</u> Middle <u>Connoley</u> Last <u>Connoley</u>			4. DATE OF DEATH Month <u>1</u> Day <u>15</u> Year <u>61</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>1/30/1881</u>	9. AGE (last birthday) <u>79</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HR Hours <u> </u> Min. <u> </u>	
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>Own Home</u>	11. BIRTHPLACE (City and state or country) <u>Wein Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>Hoelzle</u>		13b. MOTHER'S MAIDEN NAME <u>Catherind Binder</u>		14. NAME OF HUSBAND OR WIFE <u>-----</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	17. INFORMANT Address <u>Barbara Muldoon 8920 Lackland</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>Coronary Occlusion</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u> <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u> </u>				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 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.) <u> </u>				
20c. TIME OF INJURY Hour <u> </u> s.m. <u> </u> p.m. <u> </u> Month, Day, Year <u> </u>		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.) <u> </u>		20f. CITY, TOWN, OR LOCATION <u> </u>		COUNTY <u> </u>	STATE <u> </u>	
21. I attended the deceased from <u>Jan 1956</u> to <u>1-15-61</u> and last saw her alive on <u>1-13-61</u> Death occurred at <u>7:30AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <u>Norman J. Schroeder M.D.</u>			22b. ADDRESS <u>9616 Lackland Rd.</u>		22c. DATE SIGNED <u>1-16-61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1/17/1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart</u>	23d. LOCATION (City, town, or county) (State) <u>Florissant Mo</u>		25. DATE RECD. BY LOCAL REG. <u>1-16-61</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Ortmann F Home 9222 Lackland Overland Mo</u>			26. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

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 Al O. Ortman

Licensed Embalmer No. 3478

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.