

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-018408

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3134 STATE FILE NUMBER 10405

FILED APR 14 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURIE COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST LOUIS,</u>		c. CITY OR TOWN <u>ST LOUIS,</u>	
Length of stay in 1b		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>1341 NO. EUCLID AVE</u>		d. STREET ADDRESS (If outside, give location) <u>1341 NO. EUCLID AVE</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>NORA</u> Middle <u>BACON</u> Last <u>BACON</u>			4. DATE OF DEATH Month <u>APRIL</u> Day <u>1</u> Year <u>1961</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 checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11/23/1879</u>	9. AGE (last birthday) <u>81</u>	
IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____			

10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <u>HOUSEWIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>ST LOUIS MISSOURI</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
---	-----------------------------------	--	--

13a. FATHER'S NAME <u>JOHN McNICHOLAS</u>	13b. MOTHER'S MAIDEN NAME <u>BRIDGET McNICHOLAS</u>	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) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>ELLA BORTFELD</u>	Address <u>1341 NO. EUCLID AVE</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>myocardia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Several days</u>
DUE TO (b) _____		
DUE TO (c) <u>422.2</u>		

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
---	--	---

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 <u>6-15-59</u> to <u>4-1-61</u> and last saw her/him alive on <u>11/20/59</u> m on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE <u>W. H. Kane M.D.</u>	(Degree or title)	22b. ADDRESS <u>706 Malton</u>	22c. DATE SIGNED <u>4/3/61</u>
--	-------------------	-----------------------------------	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>4/4/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CALVARY CEMETERY</u>	23d. LOCATION (City, town, or county) <u>ST LOUIS MISSOURI</u>
--	----------------------------	---	---

24. FUNERAL DIRECTOR <u>STROOT - CARROLL</u>	ADDRESS <u>4600 NAT'L BRIDGE</u>	25. DATE RECD. BY LOCAL REG. <u>APR 3 1961</u>	26. REGISTRAR'S SIGNATURE <u>Loard Smith. M.D.</u>
---	-------------------------------------	---	---

AMENDED
 DATE AMENDED
 THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

Dr. Allyn Kone
706 Walton
70 1-16-86
JE3-5858

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 *M W Ruster*

Licensed Embalmer No. *4865*

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.