

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

61-010920
STATE FILE NUMBER

318

1003

2312

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

AMENDED

FILED MAR 23 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) St. Louis Little Rock Hospital, Inc.		d. STREET ADDRESS (If outside, give location) 6032 Delmar	

3. NAME OF DECEASED (Type or print) First Middle Last John Theodore Hannibal			4. DATE OF DEATH Month Day Year March 7, 1961		
5. SEX Male	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 9/1/12	9. AGE (last birthday) 48	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Switchman		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (City and state or country) St. Louis, Mo.	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Theodore Hannibal		13b. MOTHER'S MAIDEN NAME Florence Doyle	
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. INFORMANT Robert J. Mullen 118 N. Florissant			17. ADDRESS		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio respiratory Failure		INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) Bronchopneumonia		
DUE TO (c) 491x		

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"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input checked="" 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.)	
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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 March 5, 1961 to March 7, 1961 and last saw him alive on March 7, 1961	
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Death occurred at 6:15 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <i>Robert J. Mullen</i> (Degree or title)		22b. ADDRESS 1755 South Grand Ave.		22c. DATE SIGNED 3-8-61
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3-10-61	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Missouri.
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24. FUNERAL DIRECTOR ADDRESS White-Mullens Ferguson, Mo. 9776		25. DATE RECD. BY LOCAL REG. MAR 9 1961	26. REGISTRAR'S SIGNATURE <i>Lead Smith M.D.</i>
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DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
SHOULD READ
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 L. M. White

Licensed Embalmer No. 3972

P. O. Address Jerguson

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.