

SOURCE DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

61-011215
STATE FILE NUMBER

318

1003

3359

AMENDED

Registration District No. 318
FILED APR 14 1961

Primary Registration District No. 1003

Registrar's No. 3359

| | | | |
|---|------------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u> | | Length of stay in 1b <u>5 days</u> | c. CITY OR TOWN <u>St. Louis</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>Incarinate Word Hospital</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>5701 Lillian</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>MARGARET</u> Middle <u>THERESA</u> Last <u>MC NAMARA</u> | | | 4. DATE OF DEATH Month <u>April</u> Day <u>9</u> Year <u>1961</u> |
| 5. SEX <u>female</u> | 6. COLOR OR RACE <u>white</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>2/12/1898</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (last birthday) <u>63 years</u> IF UNDER 1 YEAR Months Days Hours Min. |
| 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>Edward Boyce</u> | | 13b. MOTHER'S MAIDEN NAME <u>Katherine Hensiek</u> | 14. NAME OF HUSBAND OR WIFE <u>James F. McNamara</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> | | 17. INFORMANT Address <u>James McNamara - 5701 Lillian</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>acute dilatation Rt. Ventricle</u> DUE TO (b) <u>Acute Pulmonary Edema</u> DUE TO (c) <u>Arteriosclerosis Coronary Arteries</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Thyroidectomy - 4-5-61 4201</u> | | | INTERVAL BETWEEN ONSET AND DEATH |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 <u>5:30</u> a.m. Month <u>April</u> Day <u>23</u> Year <u>1953</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.) | 20f. CITY, TOWN, OR LOCATION COUNTY STATE |
| 21. I attended the deceased from <u>April 23, 1953</u> to <u>April 9, 1961</u> and last saw her/him live on <u>April 8, 1961</u> Death occurred at <u>5701 Lillian</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <u>Joseph E. Carney M.D.</u> (Degree or title) | | 22b. ADDRESS <u>906 Olive St</u> | 22c. DATE SIGNED <u>4-10-61</u> |
| 23a. BURIAL, CREMATION, EMBOWAL (Specify) <u>burial</u> | 23b. DATE <u>April 12, 1961</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>St. Louis Missouri</u> |
| 24. FUNERAL DIRECTOR <u>BUCHHOLZ MORTUARY - 5967 W. Florissant</u> | | 25. DATE RECD. BY LOCAL REG. <u>APR 10 1961</u> | 26. REGISTRAR'S SIGNATURE <u>Ed Smith, M.D.</u> |

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SHOULD READ

ITEM NO.

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 Walter D. Buckwalter

Licensed Embalmer No. 4557

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.