

FILED VS MAR 13 1961

61-011307

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1920

AMENDED

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

|   |                               |   |  |   |  |   |   |  |           |  |  |
|---|-------------------------------|---|--|---|--|---|---|--|-----------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Mo</b>  |                               |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo</b> b. COUNTY |  |   |   |  |           |  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St Louis Mo</b>   |                               | Length of stay in 1b<br><b>4-Months</b>   |  | c. CITY OR TOWN <b>St Louis Mo</b>  |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   |   |  |           |  |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Little Flower Conv. Home</b><br><b>2500 South 18th St</b>   |                               |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   | d. STREET ADDRESS (If outside, give location)<br><b>6188 McPherson Ave</b> |   | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |           |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Katherine</b> Middle Last <b>Murphy</b>   |                               |   |  | 4. DATE OF DEATH<br>Month <b>2</b> Day <b>24</b> Year <b>61</b>   |  |   |   |  |           |  |  |
| 5. SEX <b>Female</b>  | 6. COLOR OR RACE <b>White</b> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>3-22-1879</b>   | 9. AGE (last birthday)<br><b>81</b>   | IF UNDER 1 YEAR<br>Months Days   | IF UNDER 24 HR<br>Hours Min.  |   |  |           |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House Wife</b>  |                               |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>House Wife</b>                               |   | 11. BIRTHPLACE (City and state or country)<br><b>St Louis Mo</b>           |   | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>  |  |           |  |  |
| 13a. FATHER'S NAME<br><b>Michael P. Sullivan</b>  |                               |   | 13b. MOTHER'S MAIDEN NAME<br><b>Margaret Holloman</b>                                |   |  | 14. NAME OF HUSBAND OR WIFE<br><b>John J. (Deceased)</b>  |   |  |           |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                               |   | 16. SOCIAL SECURITY NO.<br><b>~~~~~</b>  |   | 17. INFORMANT Address<br><b>Miss Mary A. Murphy 6188 McPherson Ave</b>     |   |   |  |           |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b>   |                               |   |  |   |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 wks</b> |           |  |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  |                               |   | DUE TO (b) <b>Generalized Arteriosclerosis</b>                                       |   |  | DUE TO (c) <b>450.0</b>   |   |  | 10-15 yrs |  |  |
| 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.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |   |  |           |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>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 <b>December 1960</b> to <b>February 21, 1961</b> and last saw her alive on <b>February 22, 1961</b><br>Death occurred at <b>February 24, 1961 8:30A</b> on the date stated above, and to the best of my knowledge, from the causes stated. |                               |   |  |   |  |   |   |  |           |  |  |
| 22a. SIGNATURE (Ink or title)<br><b>Leonard N. Piccione M.D.</b>  |                               |   |  |   | 22b. ADDRESS<br><b>6303 Natural Bridge</b>                                 |   |   | 22c. DATE SIGNED<br><b>2-25-61</b>               |           |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                               | 23b. DATE<br><b>2-27-1961</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Calvary Cemetery</b>                        |   |  | 23d. LOCATION (City, town or county)<br><b>St Louis Mo</b>  |   |  | (State)   |  |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Arthur J. Donnelly 3840 Lindell Blvd</b>   |                               |   |  | 25. DATE RECD. BY LOCAL REG.<br><b>FEB 26 1961</b>  |  | 26. REGISTRAR'S SIGNATURE<br><b>Coal Smith, M.D.</b>  |   |  |           |  |  |

130 to 40 PM

**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 Francis Hillion

Licensed Embalmer No. 3562

P. O. Address 3840 Lind

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.