MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS MAR 13 1961

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2107 STATE FILE NUMBER 61-011344

AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.	SHOULD READ	INSTEAD OF	DATE AMENDED

BY AFFIDAVIT OF DOCUMENT

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b: 36 Days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St. Lukes Hospital
Inside Limits: Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: St. Louis
c. CITY OR TOWN: St. Ann
Inside Limits: Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location): 4312 Cypress Rd.
Reside on Farm: Yes ☐ No ☑

3. NAME OF DECEASED (Type or print): First: Lois Middle: C. Last: O'Leary
4. DATE OF DEATH: Month: Feb. Day: 28 Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 9)25)1913
9. AGE (last birthday): 47
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HR: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Secretary
10b. KIND OF BUSINESS OR INDUSTRY: Office
11. BIRTHPLACE (City and state or country): St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Cornelius F. O'Leary
13b. MOTHER'S MAIDEN NAME: Catherine G. Mc Niff
14. NAME OF HUSBAND OR WIFE: Single
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): No
17. INFORMANT: Betty Moeller Address: 4312 Cypress Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Plasma Cell Myeloma
INTERVAL BETWEEN ONSET AND DEATH: 6 Months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): 203 X
DUE TO (c):
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. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 5-2-59 to 2-28-61 and last saw her/him alive on 2-26-61
Death occurred at about 4 00 p m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: [signature] (Degree or title): M D
22b. ADDRESS: 35 N Central, Clayton Mo
22c. DATE SIGNED: 3-2-61

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 3)3)1961
23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis, Mo.

24. FUNERAL DIRECTOR: Collier Mortuary, St. Ann, Mo. ADDRESS
25. DATE RECD. BY LOCAL REG.: MAR 2 1961
26. REGISTRAR'S SIGNATURE: Hoard Smith, M.D.

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 Sheldon Collier

Licensed Embalmer No. 3382

P. O. Address St. Ann

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.