

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3761

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

FILED APR 27 1961

1. PLACE OF DEATH a. COUNTY <u>2 yrs.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. 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 <u>4 mo. 12 days</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Chronic Hosp.</u>		d. STREET ADDRESS (If outside, give location) <u>3427 Washington</u>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Michael</u> Middle Last <u>Tiller</u>			4. DATE OF DEATH Month <u>3</u> Day <u>13</u> Year <u>61</u>		
---	--	--	---	--	--

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1881</u>	9. AGE (last birthday) <u>79</u>	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) <u>UNK.</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Canada</u>	12. CITIZEN OF WHAT COUNTRY <u>unk</u>
--	-----------------------------------	---	---

13a. FATHER'S NAME <u>Unk.</u>	13b. MOTHER'S MAIDEN NAME <u>Unk.</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)	16. SOCIAL SECURITY NO.	17. INFORMANT <u>Hospital Records</u>	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) <u>CORONARY ARTERY OCCLUSION</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 Hours</u>
DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u>		SEVERAL YEARS
DUE TO (c) <u>420.0</u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>(2) ANEMIA (4) OLD CVA (3) HEENIA INGUINAL</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <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 <u>3:16</u> 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 <u>St. Louis, Mo.</u>	COUNTY	STATE
---	--	--	---	--------	-------

21. I attended the deceased from <u>11-2-59</u> to <u>3-13-61</u> and last saw <sup>her</sup> <sub>him</sub> alive on <u>3-13-61</u> Death occurred, at <u>3:16 p.m.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE <u>John X. Keeney, M.D.</u> (Degree or title)	22b. ADDRESS <u>5800 Arsenal</u>	22c. DATE SIGNED <u>3-14-61</u>
--	-------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>APR 29 1961</u>	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>
---	-----------	---	--

24. CORONER'S OFFICE ADDRESS <u>St. Louis Mortuary</u> <u>4104 Manchester Av.</u>	25. DATE RECD. BY LOCAL REG. <u>APR 20 1961</u>	26. REGISTRAR'S SIGNATURE <u>Paul Smith, M.D.</u>
---	--	--

MEDICAL CERTIFICATION

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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.