

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-023565

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 1687

AMENDED

FILED JUL 7 1961

| | | | | | |
|--|--|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY St. Louis | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY _____ | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Richmond Hts. | | Length of stay in 1b 2 Days | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF HOSPITAL OR INSTITUTION St. Mary's Hospital | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 6494 Oakland Ave. | |
| Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last CATHERINE PHELAN | | | 4. DATE OF DEATH Month Day Year June 15 1961 | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 10-23-1876 | 9. AGE (last birthday) 84 | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework | | 10b. KIND OF BUSINESS OR INDUSTRY At Home | 11. BIRTHPLACE (City and state or country) Ireland | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME Michael Rooney | | 13b. MOTHER'S MAIDEN NAME Unknown Dempsey | | 14. NAME OF HUSBAND OR WIFE Late Patrick J. Phelan | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | 17. INFORMANT Address Michael V. Phelan 5820 Neosho St. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Gastro-Intestinal | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Hemorrhagic Gastritic | | | | | |
| DUE TO (c) Prepyhoric Ulcer-Sicchosis-Hepatoma of Liver | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 540.0H | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 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.) | |
| 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 | |
| 21. I attended the deceased from <u>Aug 2, 1960</u> to <u>6/15/61</u> and last saw her <u>him</u> alive on <u>6/15/1961</u> Death occurred at <u>2:27 p.m.</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) <u>Thomas W. Parker M.D.</u> | | | 22b. ADDRESS <u>4660 Maryland</u> <u>St. Louis, Mo</u> | | 22c. DATE SIGNED <u>6/16/61</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 23b. DATE <u>June 17, 1961</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u> | | |
| 24. FUNERAL DIRECTOR ADDRESS <u>Kriegshauser 4228 S. Kingshighway Blvd.</u> | | 25. DATE RECD. BY LOCAL REG. <u>6-16-61</u> | 26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u> | | |

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

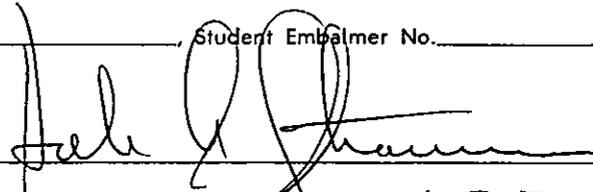
ITEM NO. SHOULD READ

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  _____

Licensed Embalmer No. 4533

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.