

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-030929
 STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7910

FILED SEP 6 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>3 1/2 weeks</u>	a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>De Paul Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Country Club Hills</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
		d. STREET ADDRESS (If outside, give location) <u>7529 Calvin Avenue</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>M</u> Last <u>McCoyne</u>	4. DATE OF DEATH Month <u>August</u> Day <u>24</u> Year <u>1961</u>
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5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIAGE STATUS Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6-4-1890</u>	9. AGE (last birthday) <u>71</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (City and state or country) <u>Hannibal, Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Tillmann</u>	13b. MOTHER'S MAIDEN NAME <u>Kate Diehl</u>	14. NAME OF HUSBAND OR WIFE <u>deceased</u>
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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>Mrs. Henry Bader, 7529 Calvin Avenue</u>
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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>Broncho pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u>
DUE TO (b) <u>Intercostal Ribs fractured left</u>		
DUE TO (c) <u>Femur & Coxal Vena Deficiency</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>8-28-61</u>		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 type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>Patient fell at home</u>
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20c. TIME OF INJURY Hour <u>7</u> a.m. <u>29</u> p.m. <u>61</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.) <u>home</u>	20f. CITY, TOWN, OR LOCATION <u>7529 Calvin Country Club Hills Mo.</u>	COUNTY <u> </u> STATE <u> </u>
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21. I attended the deceased from <u>July 29, 61</u> to <u>Aug 23/61</u> and last saw her <u>alive</u> on <u>Aug 23, 61</u> . Death occurred at <u>3:45 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Joseph A. Costello M.D.</u>	22b. ADDRESS <u>2425 N B'way, St Louis</u>	22c. DATE SIGNED <u>8/25/61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>August 26, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New St. Marcus Cemetery</u>	23d. LOCATION (City, town, or county) <u>St. Louis County, Missouri</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Math Hermann & Son, Inc., 2161 E. Fair Av</u>	25. DATE RECD. BY LOCAL REG. <u>AUG 25 1961</u>	26. REGISTRAR'S SIGNATURE <u>Donald Smith M.D.</u>
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AMENDED
 DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTead OF
 DOCUMENT
 MEDICAL CERTIFICATION
 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 Shelton W. Hahn

Licensed Embalmer No. 3737

P. O. Address St. Louis Mo

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.