

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-031366

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2275

FILED SEP 1 1961

AMENDED

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

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| 1. PLACE OF DEATH a. COUNTY <u>Koch ST. Louis</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis Koch, Mo</u> Length of stay in 1b <u>27 days</u> | | c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Robert Koch Hosp.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>608 Schiller Ave</u> Reside on Farm: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary L. McCarey</u> | | | 4. DATE OF DEATH Month Day Year <u>Aug. 12, 1961</u> |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>white</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>9-30-1899</u> |
| 9. AGE (last birthday) <u>71</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>me</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>nil</u> | 11. BIRTHPLACE (City and state or country) <u>Indiana</u> |
| 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | | 13a. FATHER'S NAME <u>Nolan, D.F.</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>Mary J.</u> | | 14. NAME OF HUSBAND OR WIFE <u>Albert R. McCarey</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 17. INFORMANT Address <u>Records at Robert Koch Hospital</u> | |
| 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> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>49ix</u> DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH <u>12 days.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>cerebral artery thrombosis</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 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 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>7-17-61</u> to <u>8-12-61</u> and last saw her <u>8-12-61</u> alive on <u>8-12-61</u> Death occurred at <u>12:25 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>Bernard Freedman, M.D.</u> | | 22b. ADDRESS <u>Koch Hosp. Koch Mo.</u> | 22c. DATE SIGNED <u>8-12-61</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u> | 23b. DATE <u>8/16/61</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>Emil J. Heitzenroeder, 8319 Hallsferry</u> | | 25. DATE RECD. BY LOCAL REG. <u>8-14-61</u> | 26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u> |

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SW. TOLLING

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 John J. Haines

Licensed Embalmer No. 4108

P.O. Address Haines 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.

STATEMENT TO COMMISSION