

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-039472

AMENDED

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 2957 STATE FILE NUMBER

FILED NOV 8 1961

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>Richmond Heights</b>		Length of stay in 1b <b>1 1/2 DAYS</b>	c. CITY OR TOWN <b>University City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Mary's Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>7230 Carnell</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>BRENDAN</b> Middle <b>TERRENCE</b> Last <b>CONNAUGHTON</b>	4. DATE OF DEATH Month <b>Oct.</b> Day <b>20,</b> Year <b>1961</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>10-19-61</b>	9. AGE (last birthday) IF UNDER 1 YEAR: Months <b>1 1/2</b> Days <b>12</b>	IF UNDER 24 HR: Hours <b>12</b> Min. <b>00</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	11. BIRTHPLACE (City and state or country) <b>Richmond Heights U. S. A.</b>	12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>
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13a. FATHER'S NAME <b>James P. Connaughton</b>	13b. MOTHER'S MAIDEN NAME <b>Katherine Hardesty</b>	14. NAME OF HUSBAND OR WIFE <b>-----</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>James P. Connaughton 7230 Carnell</b>
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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) <b>IntraCranial Hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) <b>Ventricular &amp; Subarachnoid</b>		
DUE TO (c) <b>Large Arteriovenous Septal Defect</b>		
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. <input type="checkbox"/> Yes <input 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.)
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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
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21. I attended the deceased from 10-19-61 to 10-20-61 and last saw her alive on 10-20-61  
Death occurred at 3 PM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>James B. Danahar, M.D.</b>	22b. ADDRESS <b>950 Francis Place Clayton</b>	22c. DATE SIGNED <b>10-21-61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>Oct. 23, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Belleville Ill.</b>
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24. FUNERAL DIRECTOR ADDRESS <b>A. H. Bocklage 6536 Clayton Rd.</b>	25. DATE RECD. BY LOCAL REG. <b>10-21-61</b>	26. REGISTRAR'S SIGNATURE <b>John C. Murphy M.D.</b>
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

**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 Not Embalmed

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.