

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-046245

AMENDED

Registration District No. **318**

1003

Registrar's No. **11481**

STATE FILE NUMBER

FILED DEC 18 1961

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

1. PLACE OF DEATH a. COUNTY		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 St. Louis, Mo.		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DePaul.		d. STREET ADDRESS (If outside, give location) 5711 Pennsylvania.	

3. NAME OF DECEASED (Type or print) First Irene Middle Dunphy. Last			4. DATE OF DEATH Month Dec. Day 8 Year 61		
5. SEX Female.	6. COLOR OR RACE White.	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8-31-77	9. AGE (last birthday) 74	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Texas.	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Unk.		13b. MOTHER'S MAIDEN NAME Unk.	

14. NAME OF HUSBAND OR WIFE Thomas F. Dunphy. Mo.		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT Address Thos. F. Dunphy 5711 Pa., St. Louis	
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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) Cerebral anoxia			INTERVAL BETWEEN ONSET AND DEATH 16 days.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral Thrombosis			
DUE TO (c) Diabetes Mellitus			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 260x		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	
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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 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
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21. I attended the deceased from **1956** to **1961** and last saw her/him alive on **12.7.61**
Death occurred at **2 PM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Donald L. Otter M.D.	22b. ADDRESS 730 HODIAMONT	22c. DATE SIGNED 12.9.61
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23a. BURIAL, CREMATION, REMOVAL (Specify) 12-11-1961	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY Calvary.	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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24. FUNERAL DIRECTOR ADDRESS Southern Funeral Home. 5322 S. Grand Blvd.	25. DATE RECD. BY LOCAL REG. DEC 9 1961	26. REGISTRAR'S SIGNATURE Loan Smith, M.D.
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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 David Van Borsow.

Licensed Embalmer No. 4242

P. O. Address 57 Lewis Ave

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.