

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

#61-047291  
STATE FILE NUMBER

Primary Registration District No. 547 Registrar's No. 3604  
 Filing District No. 317 FILED JAN 9 1962

AMENDED

DATE AMENDED

INSTEAD OF

DOCUMENT

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>Livingston</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Richmond Heights</b>		c. CITY OR TOWN <b>Wheeling</b>	
Length of stay in lb <b>1 week</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Mary's Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>Rural Route #1</b>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ELIZABETH AGNES MCKENZIE</b>			4. DATE OF DEATH Month Day Year <b>Dec. 19 1961</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5-16-1883</b>
9. AGE (last birthday) <b>78</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (City and state or country) <b>Wheeling, Mo.</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>			
13a. FATHER'S NAME <b>Edward Hogan</b>		13b. MOTHER'S MAIDEN NAME <b>Anna Franklin</b>	14. NAME OF HUSBAND OR WIFE <b>William McKenzie</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		17. INFORMANT Address <b>Mrs. Fred Klipstein Cheyenne, Wyo</b>	
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>Cerebral Thrombosis with Hemiplegia Left.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>12/5/61</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerosis.</b>			
DUE TO (c) <b>Diabetes Mal.</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 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 Hour Month, Day, Year a.m. p.m.			
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 <b>Dec. 13, 1961</b> , to <b>Dec. 19, 1961</b> and last saw her alive on <b>Dec. 19, 1961</b> Death occurred at <b>10:15 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>James P. Hadfield M.D.</i>		22b. ADDRESS <b>634 North Grand Ave.</b>	22c. DATE SIGNED <b>12/19/61</b>
23. NAME OF CEMETERY OR CREMATORY <b>St. Patrick's Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>Wheeling, Mo.</b>	24. FUNERAL DIRECTOR ADDRESS <b>A. H. BOCKLAGE 6536 Clayton Rd.</b>	
25. DATE RECD. BY LOCAL REG. <b>12-19-61</b>		26. REGISTRAR'S SIGNATURE <i>John C. Munflay M.D.</i>	

20. BURIAL, CREMATION, REMOVAL (Specify)  
**Removal**

23b. DATE  
**Dec. 19, 1961**

23c. NAME OF CEMETERY OR CREMATORY  
**St. Patrick's Cem.**

23d. LOCATION (City, town, or county) (State)  
**Wheeling, Mo.**

24. FUNERAL DIRECTOR ADDRESS  
**A. H. BOCKLAGE 6536 Clayton Rd.**

25. DATE RECD. BY LOCAL REG.  
**12-19-61**

26. REGISTRAR'S SIGNATURE  
*John C. Munflay M.D.*

ITEM NO.

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

**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 J. W. Dinkley

Licensed Embalmer No. 3653

P. O. Address St. Louis 86

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.