

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-047344

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 3511

FILED DEC 18 1961

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Richmond Heights</u>		Length of stay in lb <u>2 weeks</u>	c. CITY OR TOWN <u>Olivette</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>St. Marys Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1141 Brightling Dr.</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>May</u> Last <u>O'HARA</u>	4. DATE OF DEATH Month <u>December</u> Day <u>10</u> Year <u>1961</u>
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5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>12-20-09</u>	9. AGE (last birthday) <u>51</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>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (City and state or country) <u>Madison, Wisc.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>Joseph E. Hillemeier</u>	13b. MOTHER'S MAIDEN NAME <u>Ida Shepard</u>	14. NAME OF HUSBAND OR WIFE <u>James D. O'Hara</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>	16. SOCIAL SECURITY NO. <u> </u>	17. INFORMANT Address <u>Mr. James D. O'Hara; 1141 Brightling</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>Carcinoma of lung</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 Mo</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u> </u>		
DUE TO (c) <u> </u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>metastases to brain - bone - liver</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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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 <u> </u> Month, Day, Year <u> </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.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from 10/9/61 to 12/10/61 and last saw her/him alive on 12/9/61
Death occurred at on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Print or type) <u>Joseph L. Ruide</u>	22b. ADDRESS <u>634 N. Grand</u>	22c. DATE SIGNED <u>12/11/61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-13-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Resurrection Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis County</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Alexander & Sons, 6175 Delmar Blvd.</u>	25. DATE RECD. BY LOCAL REG. <u>12-12-61</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>
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DATE AMENDED

INSTEAD OF DOCUMENT

ITEM NO. SHOULD READ

MEDICAL CERTIFICATION BY AFFIDAVIT OF

Dr. Joseph L. Lucido
Mo. Theater Bldg.
3:30 P.M. TO 5 P.M.
Phone: OL 2-4838

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 _____

Licensed Embalmer No. 4953

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.