MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-62-003722
STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1063

FILED FEB 2 1962

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
Length of stay in 1b 55-yrs.

c. CITY OR TOWN St.Louis
Inside Limits Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St.Luke's Hospital
Inside Limits Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location) 6217 Waterman Ave.
Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: William Middle: Francis Last: Fahey

4. DATE OF DEATH Month Day Year: January 23rd.,1962

5. SEX M.

6. COLOR OR RACE W.

7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐

8. DATE OF BIRTH 2/3/1884

9. AGE (last birthday) 77

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) Attorney

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country) Jerseyville,Ill.

12. CITIZEN OF WHAT COUNTRY U.S.

13a. FATHER'S NAME Patrick Fahey

13b. MOTHER'S MAIDEN NAME Bridget Unk.

14. NAME OF HUSBAND OR WIFE Catherine Fahey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address: Mr.Donald E.Fahey, 7345 Woodland Way

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Leukemia — INTERVAL BETWEEN ONSET AND DEATH: 2 months

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c) 204.3

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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 Nov 29 1961, to Jan 23 '62 and last saw her/him alive on Jan 23 '62

Death occurred at 7:00 pm. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE John M. Grant (Degree or title) M.D.

22b. ADDRESS 114 N. Taylor Av

22c. DATE SIGNED 1/24/62

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE 1/26/1962

23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery

23d. LOCATION (City, town, or county) St.Louis (State) Missouri

24. FUNERAL DIRECTOR Arthur J. Donnelly ADDRESS 3840 Lindell Blvd.

25. DATE RECD. BY LOCAL REG. JAN 24 1962

26. REGISTRAR'S SIGNATURE Fred Smith M.D.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED

BY AFFIDAVIT OF DOCUMENT

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_____ Signed Joanne Williamson

Signature of Student Embalmer

Licensed Embalmer No. 3565

P. O. Address 3840 Linde

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.