

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-004032

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **205**

AMENDED

FILED JAN 19 1962

a. COUNTY Missouri		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b D O A	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis City Hospital		d. STREET ADDRESS (If outside, give location) 5916 Goodfellow	
3. NAME OF DECEASED (Type or print) First LOUIS Middle JAMES Last KILROY		4. DATE OF DEATH Month January Day 5 Year 1962	
5. SEX male	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7/28/1901
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) plumber		10b. KIND OF BUSINESS OR INDUSTRY construction	9. AGE (last birthday) 57 years
13a. FATHER'S NAME Martin Kilroy		13b. MOTHER'S MAIDEN NAME María Geraghty	11. BIRTHPLACE (City and state or country) Ireland
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		14. NAME OF HUSBAND OR WIFE Delia Kilroy	
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Arterio Sclerosis DUE TO (c) 420.1		12. CITIZEN OF WHAT COUNTRY U. S. A.	
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 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	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Joseph M. Quinn, M.D.</i>		22b. ADDRESS 1300 Clark	
22c. DATE SIGNED 1-6-62			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE Jan 8, 1962	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Missouri
24. FUNERAL DIRECTOR BUCHHOLZ MORTUARY-5967 W. Florissant Ave		25. DATE RECD. BY LOCAL REG. JAN 6 1962	
26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>			

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

ITEM NO.

307 0 1/2 0 1/2

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 *Victor J. Bushnell*

Licensed Embalmer No. 4-5-51

P. O. Address St Louis

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.