

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER  
**762-62-009166**

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **7** **FILED MAR - 7 1962**

Primary Registration District No. **545**

Registrar's No. **762**

VS 300  
Rev. 4/59

1 **4004**

2 **205**

3

4 **1**

5 **2**

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7 **0**

8 **2**

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11

12 **86-0**

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Maplewood</b>		Length of stay in 1b <b>4 weeks</b>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Maplewood Nursing Home</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>5908 Enright Ave.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>L.</b> Last <b>Harrigan</b>			4. DATE OF DEATH Month <b>January</b> Day <b>17</b> Year <b>1962</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>1/5/1871</b>
9. AGE (last birthday) <b>91</b>		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) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>		13a. FATHER'S NAME <b>John Moynihan</b>	
13b. MOTHER'S MAIDEN NAME <b>Elizabeth (Unknown)</b>		14. NAME OF HUSBAND OR WIFE <b>Lawrence</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>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>W. Chester Kraemer, 221 Westgate</b> Address
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</b>			INTERVAL BETWEEN ONSET AND DEATH <b>January 1961</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Cerebral Arteriosclerosis</b>			<b>January 17, 1962</b>
DUE TO (c) <b>332x</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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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>January 5, 1961</b> to <b>January 17, 1962</b> and last saw her alive on <b>Jan. 17, 1962</b> . Death occurred at <b>7:30 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Angelo A. Speno M.D.</b> (Degree or title)		22b. ADDRESS <b>9313 Manchester Rd.</b>	22c. DATE SIGNED <b>Jan. 19, 1962</b> (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>1-20-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	23d. LOCATION (City, town, or county) <b>St. Louis, Mo.</b>
24. FUNERAL DIRECTOR <b>Harrigan-Sheahan, 4700 Washington Blvd.</b> ADDRESS		25. DATE RECD. BY LOCAL REG. <b>1-19-62</b>	26. REGISTRAR'S SIGNATURE <b>John M. Murphy M.D.</b>

**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 John J. Haines

Licensed Embalmer No. 4108

P. O. Address St. Louis Mo

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.