

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-013407

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 1124 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED APR 16 1962

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>ST LOUIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Richmond Heights Mo</u>		c. CITY OR TOWN <u>Richmond Heights Mo</u>	
Length of stay in lb <u>6-weeks</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St Mary's Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>7736 St Albans (17)</u>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Agnes</u> Middle <u>Brown</u> Last <u>Brown</u>			4. DATE OF DEATH Month <u>4</u> Day <u>9</u> Year <u>62</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-16-1890</u>	9. AGE (last birthday) <u>69</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HR Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (City and state or country) <u>St Louis Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Michael Dempsey</u>			13b. MOTHER'S MAIDEN NAME <u>Delia Morrisay</u>		14. NAME OF HUSBAND OR WIFE <u>Paul B. (Deceased)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT Address <u>Wm P. Brown 12145 Lake Placid Dr (41)</u>		

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>Acute Hepato cellular Necrosis of Liver due to unknown etiology</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 days</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>  </u>		
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 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.)	
20c. TIME OF INJURY Hour <u>  </u> a.m. <u>  </u> p.m. <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	
21. I attended the deceased from <u>3/12/1962</u> to <u>4/9/62</u> and last saw her alive on <u>4/8/62</u> Death occurred at <u>4:00 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Malcolm B. Bowell M.D.</u>		22b. ADDRESS <u>4660 Maryland</u>	
22c. DATE SIGNED <u>4/9/62</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE <u>4-11-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St Louis Mo</u>

24. FUNERAL DIRECTOR ADDRESS <u>Arthur J. Donnelly 3810 Lindell Blvd</u>	25. DATE RECD. BY LOCAL REG. <u>4-10-62</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>
--	---	--

VS 300 Rev. 4/59  
1 4005  
2 4005  
3  
4 1  
5 2  
6  
7 0  
8 1  
9 580 X  
10  
11  
12 1246-0  
13

DATE AMENDED  
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF  
DOCUMENT  
SHOULD READ  
BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

Ed Malcolm Bawell  
4400 Maryland Hill Blvd  
Stuy Town Moncton  
FO 1-6074

**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 Ernie Williamson

Licensed Embalmer No. 3565  
P. O. Address 3840 Lundell

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.