

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-013432

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1132

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>Missouri</u> b. COUNTY <u>St. Louis</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bellefontaine Neighbors</u> | | c. CITY OR TOWN <u>Bellefontaine Neighbors</u> | |
| Length of stay in 1b <u>18 years</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>9609 Bellefontaine Rd</u> | | d. STREET ADDRESS (If outside, give location) <u>9609 Bellefontaine Rd</u> | |

| | | | | | |
|--|-------------------------------|--|--|--|--|
| 3. NAME OF DECEASED (Type or print) First <u>MICHAEL</u> Middle <u>J</u> Last <u>CRONIN</u> | | | 4. DATE OF DEATH Month <u>April</u> Day <u>9</u> Year <u>1962</u> | | |
| 5. SEX <u>male</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>9/7/1869</u> | 9. AGE (last birthday) <u>92 years</u> | IF UNDER 1 YEAR Months Days Hours Min. |

| | | | |
|---|--|---|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>City fireman</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>City Gov.</u> | 11. BIRTHPLACE (City and state or country) <u>Dublin, Ireland</u> | 12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u> |
|---|--|---|---|

| | | |
|--|---------------------------------|--|
| 13a. FATHER'S NAME <u>Dennis Cronin</u> | 13b. MOTHER'S MAIDEN NAME _____ | 14. NAME OF HUSBAND OR WIFE <u>Julia Cronin</u> |
| 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. _____ | 17. INFORMANT Address <u>Hazel Cronin - 9609 Bellefontaine Rd.</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>Cerebral Vasculature</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>1 Week</u> <u>10 yrs</u> |
| DUE TO (b) <u>Arteriosclerosis</u> | | |
| DUE TO (c) <u>General</u> | | |

| | |
|---|--|
| 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 checked="" 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 March 10-62 to April 9-62 and last saw him alive on April 8-62
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

| | | |
|--|--|---------------------------------|
| 22a. SIGNATURE (Name or title) <u>Francis M. Miller M.D.</u> | 22b. ADDRESS <u>4114 W. Florissant</u> | 22c. DATE SIGNED <u>4/10/62</u> |
|--|--|---------------------------------|

| | | | |
|--|---------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u> | 23b. DATE <u>April 12, 1962</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u> | 23d. LOCATION (City, town, or county) <u>St. Louis Missouri</u> |
|--|---------------------------------|--|---|

| | | |
|--|---|--|
| 24. FUNERAL DIRECTOR ADDRESS <u>BUCHHOLZ MORTUARY-5967 W. Florissant Ave</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
14001
240012
3
4 0
5 2
6
7 2
8 2
9331X
10
11
1290.0
13

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

USE BLACK INK OR TYPEWRITER RIBBON

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 Royce T. Lindner

Licensed Embalmer No. 4275

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.