

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-020680

318

1003

5616

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

FILED JUN 15 1962

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY		c. CITY OR TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
		St. Louis		3 weeks		Missouri		St. Louis		Maplewood		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
Incarnate Word Hospital						2500 Bellevue Ave.							
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH			Month	Day	Year		
MARY			NMI	LOFINCK	June			3	1962				
5. SEX		6. COLOR OR RACE		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HR	
Female		White				5-30-1880		82		Months		Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY					
Retired Housewife				Own home		Cork, Ireland		USA					
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE					
David O'Leary				Mary Buckley				Ferdinand C. Lofinck					
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.		17. INFORMANT		Address					
No				None		Mrs Mildred Hite,		above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:												INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a)												18 days	
Cerebral Hemorrhage -													
DUE TO (b)													
Pt. hemiplegia since Feb 1962													
DUE TO (c)													
arteriosclerosis & Hypertension several yrs.													
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.	
Gen. debility												331X	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		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		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 <u>Oct 14, 1946</u> to <u>6-3-62</u> and last saw her alive on <u>6-2-62</u>													
Death occurred at <u>9:45 a</u> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title)						22b. ADDRESS			22c. DATE SIGNED				
John T Flynn MD M.D.						1715 So. 39th St. St. Louis, Mo.			6-5-62				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		23e. STATE					
Burial		6-6-62		Calvary Cemetery		St. Louis, Mo.							
24. FUNERAL DIRECTOR						ADDRESS		25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE			
JAY B. SMITH, Maplewood, Mo.								JUN 5 1962		Earl Smith, M.D.			

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

VS 300  
 Rev. 4/59  
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 63  
 USE BLACK INK OR TYPEWRITER RIBBON

Dr. John Flynn  
1715 So 39th St.

**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 Melvin Barteaux

Licensed Embalmer No. 4903

P. O. Address St Louis 17

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.