

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-029558

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2221

DO NOT WRITE ON THIS STUD

AMENDED

FILED AUG 13 1962	
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clayton</u> Length of stay in 1b <u>5 hrs</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis County Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u> c. CITY OR TOWN <u>Florissant</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>1271 Aspen Dr.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED First <u>JOHN</u> Middle <u>JOSEPH</u> Last <u>QUIRK</u>	
4. DATE OF DEATH Month <u>July</u> Day <u>29</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>
7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5-14-1935</u>
9. AGE (last birthday) <u>27</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Used Car Business</u>
11. BIRTHPLACE (City and state or country) <u>St. Louis Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>James Quirk</u>	13b. MOTHER'S MAIDEN NAME <u>Honora Gentry</u>
14. NAME OF HUSBAND OR WIFE <u>Ruth Quirk</u>	17. INFORMANT <u>Ross Quirk, Berkeley 34, Mo.</u> Address <u>8700 Scudder</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. <u> </u>
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound of head (left temple)</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	
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 checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Gunshot wound of head at hands of another person</u>	
20c. TIME OF INJURY <u>11:30 approx</u>	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>public road</u>
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20f. CITY, TOWN, OR LOCATION <u>Bridgeton</u> COUNTY <u>St. Louis</u> STATE <u>Missouri</u>
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at <u>5:45</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>Raymond L. Kari</u> Coroner	22b. ADDRESS <u>Clayton, Missouri</u>
22c. DATE SIGNED <u>8/2/62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8-2-1962</u>
23c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Florissant, Mo.</u>
24. FUNERAL DIRECTOR <u>The Florissant Mortuary, Florissant, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>7-31-62</u>
	26. REGISTRAR'S SIGNATURE <u>John Murphy MD</u>

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DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 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 Gene Spittars

Licensed Embalmer No. 4966

P. O. Address FLORISSANT, 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.