

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

62-036093
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9526

FILED OCT 11 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>ILL</u> b. COUNTY <u>ST. CLAIR</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		Length of stay in 1b <u>2 MONTHS</u>	c. CITY OR TOWN <u>EAST ST. LOUIS</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>De PAUL.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>841 N 76</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>J.</u> Last <u>DRISCOLL</u>			4. DATE OF DEATH Month <u>OCT</u> Day <u>3</u> Year <u>1962</u>
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</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>FEB 12 1911</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LAWYER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FIRM</u>	9. AGE (last birthday) <u>51</u> IF UNDER 1 YEAR: Months <u>51</u> Days <u></u> Hours <u></u> Min. <u></u> IF UNDER 24 HR: Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
11. BIRTHPLACE (City and state or country) <u>EAST ST LOUIS ILL.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>JOHN J DRISCOLL</u>		13b. MOTHER'S MAIDEN NAME <u>MARY E McCARVER</u>	14. NAME OF HUSBAND OR WIFE <u>MARY AGNES DRISCOLL</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>163x</u>	17. INFORMANT <u>Mary Agnes Driscoll 841 N. 76 St.</u> Address <u></u>
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary of long</u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 months</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)			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 <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>March 1962</u> to <u>Oct 1962</u> and last saw <u>he</u> alive on <u>10-2-62</u> Death occurred at <u>12:30 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (In ink or title) <u>F. Patrick Lamb M.D.</u>		22b. ADDRESS <u>8601 West Main St.</u>	22c. DATE SIGNED <u>10-3-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u></u>	23b. DATE <u>OCT 6 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MTCARMEL</u>	23d. LOCATION (City, town, or county) (State) <u>Belleville ILL.</u>
24. FUNERAL DIRECTOR <u>NELL WALSH BARNES EAST ST. LOUIS</u> ADDRESS <u></u>		25. DATE RECD. BY LOCAL REG. <u>OCT 5 1962</u>	26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u>

USE BLACK INK OR TYPEWRITER RIBBON

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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 James L. Creason

Licensed Embalmer No. 5168

P. O. Address Millstadt, Ill.

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.