

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

10777-62-043882
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. _____

FILED NOV 19 1962

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| VS 300 | AMENDMENTS ON THIS RECORD ARE AS FOLLOWS | DATE AMENDED |
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USE BLACK INK OR TYPEWRITER RIBBON

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| 1. PLACE OF DEATH a. COUNTY St. Louis | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Length of stay in 1b 8 Weeks | c. CITY OR TOWN University City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION De Paul Hospital | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 6241 North Drive Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED AKA Margaret First Margaret Middle Rosalie M Hannan | | 4. DATE OF DEATH Month Nov. Day 8 Year 1962 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 9/4/1908 |
| 9. AGE (last birthday) 54 | | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HR Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laboratory Technician | | 10b. KIND OF BUSINESS OR INDUSTRY De Paul Hospital | 11. BIRTHPLACE (City and state or country) St. Louis, Mo. |
| 12. CITIZEN OF WHAT COUNTRY USA | | 13. FATHER'S NAME James T. Hannan | |
| 14. MOTHER'S MAIDEN NAME Katherine Mullen | | 15. NAME OF HUSBAND OR WIFE None | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 17. SOCIAL SECURITY NO. _____ | |
| 18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of liver | | INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) unknown whether primary | | DUE TO (c) secondary | |
| 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 checked="" 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 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 1-20-61 to 11-8-62 and last saw her ^{her} _{him} alive on 11-8-62 | | Death occurred at 12:45 P.M. on the date stated above, and to the best of my knowledge, from the causes stated. | |
| 22a. SIGNATURE Wayne D. Borlaug (Degree or title) | | 22b. ADDRESS 1800 No Euclid | 22c. DATE SIGNED 11-9-62 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 11/10/1962 | 23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | |
| 24. FUNERAL DIRECTOR Alexander & Sons | | 25. DATE RECD. BY LOCAL REG. NOV 9 1962 | |
| ADDRESS 6175 Delmar | | REGISTRAR'S SIGNATURE Paul Smith, M.D. | |

Dr. Wayne Gorla
100 N. Euclid
Fo.1-8687

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 J. Allen Davis Jr.

Licensed Embalmer No. 46573

P. O. Address 117
Nov 8-1964

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.