

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-044522

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11763 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

**FILED DEC 14 1962**

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>St. Louis</u>   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo.</u> b. COUNTY                                      |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>St. Louis, Mo.</u> Length of stay in 1b   |   | c. CITY OR TOWN <u>St. Louis, Mo.</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>Jewish Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |   | d. STREET ADDRESS (If outside, give location) <u>5616 Pershing Ave.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><u>Michael J. Ledwidge</u>   |   |   | 4. DATE OF DEATH Month Day Year<br><u>December 7, 1962</u>   |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>White</u>  | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>1/20/1879</u>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Printer</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Industrial Printer</u>  | 11. BIRTHPLACE (City and state or country)<br><u>St. Louis, Mo.</u>  |
| 13a. FATHER'S NAME<br><u>John Ledwidge</u>  |   | 13b. MOTHER'S MAIDEN NAME<br><u>Mary Keating</u>  | 14. NAME OF HUSBAND OR WIFE<br><u>Margaret Ledwidge (dec)</u>  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No.</u>  |   | 16. SOCIAL SECURITY NO.   | 17. INFORMANT Address<br><u>Jean M. Ledwidge, 5616 Waterman Ave.</u>   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute myocardial Infarction</u><br>DUE TO (b) <u>Arteriosclerotic Heart Disease</u><br>DUE TO (c) <u>420.0</u><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>one hour</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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| 19. WAS AUTOPSY PERFORMED?<br>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 <u>Nov. 1961</u> to <u>Dec. 7, 1962</u> and last saw her/him alive on <u>Dec. 7, 1962</u><br>Death occurred at <u>Dec. 7, 1962 8:00p</u> m on the date stated above, and to the best of my knowledge, from the causes stated.  |   |   |  |
| 22a. SIGNATURE (Degree or title)<br><u>Paul L. Lynn, M.D.</u>   |   | 22b. ADDRESS<br><u>166 N. Euclid</u>  | 22c. DATE SIGNED<br><u>Dec 8/1962</u>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  | 23b. DATE<br><u>Dec. 10, 1962</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Calvary Cemetery</u>   | 23d. LOCATION (City, town, or county) (State)<br><u>St. Louis, Missouri</u>  |
| 24. FUNERAL DIRECTOR ADDRESS<br><u>Arthur J. Donnelly 3840 Lindell Blvd.</u>  |   | 25. DATE RECD. BY LOCAL REG.<br><u>Dec. 8, 1962</u>   | 26. REGISTRAR'S SIGNATURE<br><u>Paul Smith: M.D.</u>   |

At Central High  
100 N Emerald  
1-3

STATE OF ILLINOIS

**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 *[Handwritten Signature]*

Licensed Embalmer No. 4699

P. O. Address 3840 *[Handwritten Address]*

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.