

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-044699

STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **818**

Primary Registration District No. \_\_\_\_\_

Registrar's No. **11336**

DO NOT WRITE ON THIS STUB

AMENDED

**FILED NOV 30 1962**

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Lukes Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>14 North Kingshighway</b>	
Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Howard Lawrence O'Fallon Jr.</b>			4. DATE OF DEATH Month Day Year <b>November 25, 1962</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5-20-1906</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Civil Defense</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <b>56</b>
11. BIRTHPLACE (City and state or country) <b>St. Louis Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Howard Lawrence O'Fallon Sr.</b>		13b. MOTHER'S MAIDEN NAME <b>Mary McRee</b>	14. NAME OF HUSBAND OR WIFE <b>none</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>yes</b>		16. SOCIAL SECURITY NO. <b>[REDACTED]</b>	
17. INFORMANT <b>Mrs. Mary McRee O'Fallon-14 North Kings-</b>		Address <b>highway</b>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) DUE TO (b)			
DUE TO (c) <b>331X</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Essential hypertension</b>			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 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 <b>September 1958</b> to <b>Nov 25, 1962</b> and last saw her alive on <b>Nov 24, 1962</b> Death occurred at <b>5:00 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Michael M. Karl MD</b>		22b. ADDRESS <b>4652 MARYLAND</b>	22c. DATE SIGNED <b>11/26/62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>11-27-1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bellefontaine Cemetery</b>
23d. LOCATION (City, town, or county) <b>St. Louis Missouri</b>		23e. DATE RECD. BY LOCAL REG. <b>11-26-62</b>	
24. FUNERAL DIRECTOR <b>Lupton Chapel Inc. 7233 Delmar Bly'd.</b>		26. REGISTRAR'S SIGNATURE <b>Paul Smith, M.D.</b>	

USE BLACK INK OR TYPEWRITER RIBBON

*81*

Dr. Michael Karl  
4652 Maryland  
Ft. 74057  
12:00-5:00 Mon

O'Fallon  
City Vise.

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 Arnold W. Schoene

Licensed Embalmer No. 3864

P. O. Address St. Louis, 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.