

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-044794

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11716

FILED DEC 14 1962

VS 300 Rev. 4/59	DATE AMENDED				
1	5				
2	23				
3					
4	0				
5	1				
6					
7	0				
8	2				
9					
10					
11					
12	65-0				
13					
65					

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>ST. LOUIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Mo.</u>		Length of stay in 1b <u>5 Days</u>	c. CITY OR TOWN <u>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>Lutheran Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>9309 Laverne Place 23</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANCIS MICHAEL ROHAN</u>			4. DATE OF DEATH Month Day Year <u>December 5 1962</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</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>1/20/1904</u>
9. AGE (last birthday) <u>58</u>		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) <u>Vice President, Land Title</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance Co.</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>James M. Rohan</u>	
13b. MOTHER'S MAIDEN NAME <u>Mae Wathen</u>		14. NAME OF HUSBAND OR WIFE <u>Mrs. Mae Rohan</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>		17. INFORMANT Address <u>Mrs. Mae Rohan 9309 Laverne Place</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Decompensation</u>			INTERVAL BETWEEN ONSET AND DEATH <u>72 H.</u>
DUE TO (b) <u>Severe Pulmonary Embolism.</u>			<u>5 yrs.</u>
DUE TO (c) <u>527.1</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 a.m. Month, Day, Year p.m.	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 on <u>4-14-59</u> , to <u>12-5-62</u> and last saw her/him alive on <u>12-5-62</u> . Death occurred at <u>9:00 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>William W Farley M.D.</u>		22b. ADDRESS <u>3654 S. Grand.</u>	22c. DATE SIGNED <u>12-6-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Dec. 10, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>
24. FUNERAL DIRECTOR <u>Rather D. Wandler</u> ADDRESS <u>3840 Lindell Blvd.</u>		25. DATE RECD. BY LOCAL REG. <u>DEC 6 - 1962</u>	26. REGISTRAR'S SIGNATURE <u>Paul Smith, M.D.</u>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

DR. W. FARLEY
3654 S. GRAND

PR. 6-3146

Room 104

FOR FURNISHING

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 

Licensed Embalmer No. 4699

P. O. Address 3840 Lindell

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.