

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-048518

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12417

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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1250-0

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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

FILED JAN 2 1962	
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u> Length of stay in lb c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Alexian Brothers Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>4042 Palm Street</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET LAVIN</u>	
4. DATE OF DEATH Month Day Year <u>December 24, 1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>4-3-1878</u>
9. AGE (last birthday) <u>84</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>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>
11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>John J. Blethroad</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Moran</u>
14. NAME OF HUSBAND OR WIFE <u>Patrick J. Lavin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No None</u>	16. SOCIAL SECURITY NO. <u>None</u>
17. INFORMANT Address <u>Mr. Patrick J. Lavin, 4042 Palm Street</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>Coronary Decomposition</u> DUE TO (b) <u>Arteriosclerosis C.V. Heart Disease</u> DUE TO (c) <u>Pneumonia left mid lobe</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Dehydration + fluid + meningitis</u>	
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 SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>4221</u>	
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>4/30/60</u> to <u>12/25/62</u> and last saw her XON alive on <u>12/25/62</u> Death occurred at <u>12:30 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>Deopuok Md</u>	22b. ADDRESS <u>1901 Madison St</u>
22c. DATE SIGNED <u>12/26/62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Dec. 27, 1962</u>
23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>CALVIN F. FEUTZ, 4828 Natural Bridge Bl.</u>	25. DATE RECD. BY LOCAL REG. <u>DEC 26 1962</u>
26. REGISTRAR'S SIGNATURE <u>Loan Smith. M.D.</u>	

USE BLACK INK OR TYPEWRITER RIBBON

Dr. Stanley Ciapciak
1901 Madison Avenue
CE 1-8898

HOURS: Wednesday, 12 Noon to 4 PM
6 to 10 PM

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 Robert E. Mahlerman

Licensed Embalmer No. 4916

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.