

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=63-022529

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 347 Primary Registration District No. 500 Registrar's No. 1762

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 4031

2 4037

3

4 1

5 1

6

7 0

8 2

9 580X

10

11

12 43-2

13

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Normandy</u>		Length of stay in 1b <u>4 days</u>	c. CITY OR TOWN <u>Riverview</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>Normandy Osteopathic Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>412 Scenic Drive</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Marie</u> Middle <u>Costello</u> Last <u>Costello</u>			4. DATE OF DEATH Month <u>June</u> Day <u>1</u> Year <u>1963</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>3-4-1904</u>
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>At Home</u>	9. AGE (last birthday) <u>59</u> IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HR: Hours <u> </u> Min. <u> </u>
11a. 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>Fred Dobrick</u>		13b. MOTHER'S MAIDEN NAME <u>Marie Henning</u>	14. NAME OF HUSBAND OR WIFE <u>John Costello</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>Mr. John Costello, 412 Scenic Drive</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>Medullary Failure</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 WK</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Respiratory alkalosis</u>			<u>1 WK</u>
DUE TO (c) <u>Acute Hepatic Necrosis</u>			<u>1 WK</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I, (a) <u>cholelithiasis</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 <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 <u> </u> a.m. <u> </u> p.m. <u> </u> Month, Day, Year <u> </u>			
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>5/25/63</u> to <u>6/1/63</u> and last saw her <u>alive</u> on <u>6/1/63</u> Death occurred at <u>8:15 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Joseph J. ...</u>		22b. ADDRESS <u>705 Chambers Rd</u> <u>St. Louis 37 MO</u>	22c. DATE SIGNED <u>6-3-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>June 4 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Bethlehem Cemetery</u>	23d. LOCATION (City, town, or county) <u>St. Louis County, Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>Math Hermann & Son, Inc., 2161 E. Fair Ave</u> <u>St. Louis, Missouri</u>		25. DATE RECD. BY LOCAL REG. <u>6-3-63</u>	26. REGISTRAR'S SIGNATURE <u>Joseph M. ...</u>

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 Julius R Brown

Licensed Embalmer No. 5146
P. O. Address Shenandoah, 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.