

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-030121

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. _____

318

Primary Registration District No. _____

1003

Registrar's No. _____

7233

STATE FILE NUMBER

FILED JUL 19 1963

VS 300	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT
Rev. 4/59				
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90	SHOULD READ	BY AFFIDAVIT OF	ITEM NO.	MEDICAL CERTIFICATION
USE BLACK INK OR TYPEWRITER RIBBON				

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4939a Winona Avenue		d. STREET ADDRESS (If outside, give location) 4939a Winona Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last Mary Agnes Kane		4. DATE OF DEATH Month Day Year July 11 1963	
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3/26/78
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (City and state or country) Cuba, Missouri	
13a. FATHER'S NAME James Fitzpatrick		14. NAME OF HUSBAND OR WIFE James P. Kane	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		17. INFORMANT Address Miss Regina D. Kane 4939a Winona Ave	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor Pulmonale DUE TO (b) Bronchial fibrosis DUE TO (c) 525x		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"/>	
20c. TIME OF INJURY Hour a.m. p.m.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 1955 to 1963 and last saw her/him alive on 7-16-63 Death occurred at 10 P m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Donald L. Otter MD		22b. ADDRESS 730 KLODIAMONT	
22c. DATE SIGNED 7-12-63			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	
23b. DATE 7/13/63		23d. LOCATION (City, town, or county) (State) St. Louis, Missouri	
24. FUNERAL DIRECTOR ADDRESS Arthur J. Donnelly 3840 Lindell Blvd		25. DATE RECD. BY LOCAL REG. JUL 12 1963	
26. REGISTRAR'S SIGNATURE Roald Smith, M.D.			

Mr. B. Carter
130 Holliamant Ave.
2:4 PM Friday

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 *Wm S. [Signature]*

Licensed Embalmer No. 4699
P. O. Address 384 [Signature]

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.

[Handwritten signature]