

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH  
DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-045184

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 11470

STATE FILE NUMBER

FILED DEC - 2 1963

DO NOT WRITE ON THIS STUB	AMENDED	
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	
SHOULD READ		
BY AFFIDAVIT OF		

JOHNSON  
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 <b>ST. LOUIS, MO</b>		a. STATE <b>MO-</b>	b. COUNTY
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSP. #1.</b>		c. CITY OR TOWN <b>ST. LOUIS</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. STREET ADDRESS <b>3400 S. GRAND</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MARGARET BANNON</b>		4. DATE OF DEATH <b>NOV. 19, 1963</b>	
5. SEX <b>Female</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>2/24/1881</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	9. AGE (last birthday) <b>82</b>
11. BIRTHPLACE (City and state or country) <b>Alton, Illinois</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13a. FATHER'S NAME <b>Michael Bannon</b>		13b. MOTHER'S MAIDEN NAME <b>Margaret Tracey</b>	
14. NAME OF HUSBAND OR WIFE <b>None</b>		17. INFORMANT Address <b>Sr. Emelie, L.S.C.P. 3400 S. Grand</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vasculer Accident</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Harsh.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Cerebral Arteriosclerosis</b>			
DUE TO (c) <b>Generalized Arteriosclerosis</b>			
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. <b>33/X</b> <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 _____ a.m. _____ p.m. _____	Month, Day, Year <b>10/2/63</b>	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 <b>11/19/63</b>	COUNTY STATE
21. I attended the deceased from <b>4:15A</b> , to _____, and last saw her/him alive on _____ Death occurred _____ m on the date stated above, and to the best of my knowledge, from the causes stated.		22b. ADDRESS <b>1515 LAFAYETTE AVE</b>	
22a. SIGNATURE <b>Alta S. Johnson</b> (Name or title)		22c. DATE <b>11/19/63</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>11/22/63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis Mo</b>
24. FUNERAL DIRECTOR ADDRESS <b>Gebken Sons 2630 Gravois Ave.</b>		25. DATE RECD. BY LOCAL REG. <b>NOV. 20 1963</b>	26. REGISTRAR'S SIGNATURE <b>Loal Smith, M.D.</b>

**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 J. Suber

Licensed Embalmer No. 4144

P. O. Address 2630 Emmer

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.