

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-050293

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 531 Registrar's No. 4034

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED JAN 3 1964

VS 300 Rev. 4/59	DATE AMENDED	
1 <u>4006</u>		
2 <u>4006</u>		
3 <u>2</u>		
4 <u>1</u>		
5 <u>1</u>		
6		
7 <u>0</u>		
8 <u>2</u>		
<u>9420.1</u>		
10		
11		
12 <u>90-0</u>		
13		
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS		
INSTEAD OF		
SHOULD READ		
BY AFFIDAVIT OF		

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>			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) <u>University City</u>		Length of stay in 1b <u>Life</u>	c. CITY OR TOWN <u>University City</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>1323 Waldron Ave</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <u>1323 Waldron Ave</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Rose Catherine McEnaney</u>			4. DATE OF DEATH Month Day Year <u>December 28, 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>10/19/1899</u>	9. AGE (last birthday) <u>64</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</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>Joseph R. Wagner</u>		13b. MOTHER'S MAIDEN NAME <u>Lizzie Leonhardt</u>		14. NAME OF HUSBAND OR WIFE <u>Edward P. McEnaney</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>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Edward P. McEnaney 1323 Waldron Ave</u>		
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertension</u>					<u>15 years.</u>
DUE TO (c)					
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 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.	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>December 16, 1963</u> to <u>Dec 20, 1963</u> and last saw her alive on <u>Dec 20, 1963</u> Death occurred at <u>7 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>H. N. Chubbickford M.D.</u>		22b. ADDRESS <u>3403 Olive St. Louis</u>		22c. DATE SIGNED <u>12/20/63</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12/31/63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Peter's Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis Co, Missouri</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Alexander &amp; Sons 6175 Delmar Blvd</u>		25. DATE RECD. BY LOCAL REG. <u>12-30-63</u>		REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>	

Dr. H.A. Shackelford

3903 Olive

J.E. 39730

2-5 PM: Mon

**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

*J. Allen Davis Jr.*

Licensed Embalmer No. 4053

P. O. Address STL

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.