

6543

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED FEB 25 1957

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. _____

1003

Registrar's No. 845

BIRTH NO. _____

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): a. STATE <u>Mo.</u> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. CITY OR TOWN <u>St. Louis</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>01 4517 Forest Park Blvd.</u>		e. STREET ADDRESS (If rural, give location) <u>2149 3600a Hereford</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>MARGARET</u> b. (Middle) _____ c. (Last) <u>QUINLIVAN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>January 25 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Feb. 17 1883</u>
9. AGE (In years last birthday) <u>74</u>	IF UNDER 1 YEAR Months _____	IF UNDER 24 HRS. Days _____	IF UNDER 1 HR. Hours _____
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 _____	11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis Mo.</u>
13a. FATHER'S NAME <u>Mike Nolan</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Meagher</u>	14. NAME OF HUSBAND OR WIFE <u>Deceased</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Robert Quinlivan, 3600a Hereford</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerotic heart disease</u> ANTECEDENT CAUSES <u>+ Diabetes Mellitus</u> Forbidding conditions, if any, giving rise to the above cause (a) stating the underlying cause last: DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>4200</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from <u>Jan 1</u> , 19 <u>57</u> , to <u>Jan 25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/20</u> , 19 <u>57</u> , and that death occurred at <u>5:15 A. m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>Ralph Berg MD</u> (Degree or title)		23b. ADDRESS <u>3203 S Grand</u>	23c. DATE SIGNED <u>1/26/57</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>1/28/57</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis Mo.</u>
DATE REC'D BY LOCAL REG. <u>JAN 28 '57</u>	REGISTRAR'S SIGNATURE <u>J. Carl Smith MD</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Sullivan's 2849 No. Euclid Ave.</u>	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 *Albert Hasfield*.....

Licensed Embalmer No. *307*.....

P. O. Address *St. Louis*.....

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.

Printed