

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41898
STATE FILE NUMBER
Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9383

FILED NOV 21 1957

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1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION City Hospital # 1		Length of stay in lb	d. STREET ADDRESS 213 10 5800 Arsenal		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Patrick Delea			4. DATE OF DEATH Month Day Year Oct. 7, 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 29, 1862	9. AGE (In years last birthday) 95	10. UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired bricklayer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Ireland	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13a. FATHER'S NAME Patrick Delea		13b. MOTHER'S MAIDEN NAME Margaret Toomey		14. NAME OF HUSBAND OR WIFE Christine		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No. Nil.		16. SOCIAL SECURITY NO. None	17. INFORMANT Address John C. Delea 8117 Green St. Chicago, Ill.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. CAUSE OF DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Fracture of Skull; Subdural Hematoma</i>					INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>suffered when the deceased was trying to get into another patient's bed while in a confused state.</i>						
DUE TO (c) <i>and was pushed up the patient and slipped fell.</i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>and chronic.</i>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in PART I (a) or (b) if of item 18) <i>at the home on Hill St. St. Louis. Hospital about 145 am.</i>					
20c. TIME OF INJURY Hour a.m. Month, Day, Year 145 10 7 57	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.) 13 Hospital		20f. CITY, TOWN, OR LOCATION St. Louis Mo.	COUNTY 45 STATE E 902.7	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <i>125 P.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <i>James M. Kelly</i>			22b. ADDRESS <i>1300 Clark</i>		22c. DATE SIGNED <i>10.8.57</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10-9-57	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis, Mo.		
24. FUNERAL DIRECTOR Albert H. Hoppe 4700 Washington.		25. DATE RECD. BY LOCAL REG. OCT 8 '57	26. REGISTRAR'S SIGNATURE <i>Carl Smith MD</i> mjb			

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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. W. Wilkinson*

Licensed Embalmer No. *3575*
P. O. Address *U. Louisville*

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.