

FILED JAN 7 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

468866
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3042

300
1-57

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lemay</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Lemay</u> <u>4860</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>157 Lemay Gardens Dr. 13 yrs.</u>		d. STREET ADDRESS (If outside, give location) <u>157 Lemay Gardens Dr.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>W.</u> Last <u>Quinn</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>1</u> Year <u>1957</u>			
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 23, 1874</u>	9. AGE (In years last birthday) <u>83</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pensioned</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Maintainance Man</u>	11. BIRTHPLACE (City and state or country) <u>Nashville, Tennessee</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Michael Quinn</u>	13b. MOTHER'S MAIDEN NAME <u>Julia Martin</u>	14. NAME OF HUSBAND OR WIFE <u>Elizabeth Kelly Quinn</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Joseph M. Quinn 157 Lemay Gardens Dr. Lemay,</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Luparet & Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hr</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Chronic cardiac - vascular heart disease</u>	<u>second year</u>	
	DUE TO (c) <u>4/201</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	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 bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from <u>1950</u> to <u>1959</u> and last saw her/him alive on <u>12-1-57</u> Death occurred at <u>6:15 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Erwin S. Guehring M.D.</u>	22b. ADDRESS <u>752 Lemay Ferry Rd.</u>	22c. DATE SIGNED <u>12.3.57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Dec. 4, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Lemay; Missouri</u>
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24. FUNERAL DIRECTOR ADDRESS <u>C. Hoffmeister Mortuaries 7814 So. Broadway St. Louis, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>12-3-57</u>	26. REGISTRAR'S SIGNATURE <u>Hubert S. Conkling</u>
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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

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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 *Linus C. Hoffmann*

Licensed Embalmer No. *3871*
P. O. Address *7814 S. Brook*

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.