

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-038365

STATE FILE NUMBER

FILED OCT 23 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

9757

300
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo.	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Bethesda Hospital		d. STREET ADDRESS (If outside, give location) 414 N. Union Blvd.	
Length of stay in lb 6-wks.		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Ida Quirk Yore			4. DATE OF DEATH Month Day Year October 11th. 1958
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 15, 1880
9. AGE (In years last birthday) 78		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife-at home	11. BIRTHPLACE (City and state or country) Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Patrick Quirk	
13b. MOTHER'S MAIDEN NAME Louise Mariott		14. NAME OF HUSBAND OR WIFE Larry Yore	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Robert Jones, # 70 Chafford Woods		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO (b) DUE TO (c) Cerebral Aneurysm, Left Ventricle Direct. Left Ventricle Fall at home Aug 10 - 1958			INTERVAL BETWEEN ONSET AND DEATH 6 wks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) E904.021			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 or PART II of item 18.) Falls to kept. Balance	
20c. TIME OF INJURY Hour Month, Day, Year p.m. Aug 10 - 1958		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.) Home	
20e. CITY, TOWN, OR LOCATION St. Louis Mo.		20f. COUNTY STATE	
21. I attended the deceased from Death occurred at 10 a.m. July 23, 1958 to Oct 11, 1958 and last saw her alive on Oct 11, 1958.		22. SIGNATURE (Degree or title) M.D.	
22b. ADDRESS 7500 Oleander St. Smith MO		22c. DATE SIGNED 10-11-58	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Oct. 14, 1958	
23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis, Missouri	
24. FUNERAL DIRECTOR Michael J. Donnelly		25. DATE RECD. BY LOCAL REG. OCT 14 '58	
26. REGISTRAR'S SIGNATURE M.D.B.		27. ADDRESS 3840 Lindell Blvd.	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

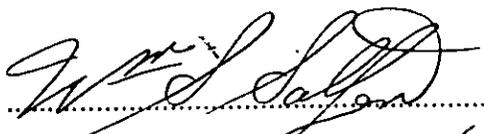
All diseases in Part I must be causally related.

4500

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 

Licensed Embalmer No. 4699

P. O. Address 3840 Lindley

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.