

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011256
STATE FILE NUMBER
2 1958

FILED MAR 27 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

300
1-57
3
296
0

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		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 home or hospital or institution) St. Anne's Home HOSPITAL OR INSTITUTION 5301 Page Ave.		d. STREET ADDRESS (If outside, give location) 5301 Page	
Length of stay in 1b 74 yrs.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Florence Middle G. Last O'Connell			4. DATE OF DEATH Month February Day 21 Year 1959		
---	--	--	--	--	--

5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 26, 1884	9. AGE (In years birthday) 74	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
-------------------------	----------------------------------	---	--	---	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.
---	-----------------------------------	---	---

13a. FATHER'S NAME Maurice O'Connell	13b. MOTHER'S MAIDEN NAME Margaret Kelly	14. NAME OF HUSBAND OR WIFE None
--	--	--

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 Address St. Anne's Home Records, 5301 Page
--	--	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) To cardio-vascular disease		INTERVAL BETWEEN ONSET AND DEATH 5 yrs 10 yrs
DUE TO (b) arterio-sclerosis		
DUE TO (c) 422.1		19. WAS AUTOPSY PERFORMED? NO <input checked="" type="checkbox"/> 2
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		

20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input checked="" 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 Death occurred at June 1/55 to Feb. 22/59 and last saw her ^{her} _{him} alive on Feb. 21/59 6:25 pm m on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE Dr. Wm J. Langford, M.D.	(Degree or title) 0	22b. ADDRESS 5823 Plymouth St. Louis	22c. DATE SIGNED Feb. 23/59
---	----------------------------	--	---------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2-24-59	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 Blvd.	ADDRESS	25. DATE RECD. BY LOCAL REG. FEB 24 '59	26. REGISTRAR'S SIGNATURE Roan Smith, M.D.
---	---------	---	--

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Medical Certification
All diseases in Part I must be causally related.

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 *Melvin R. Kemper*

Licensed Embalmer No. *4052*

P. O. Address *H.G. 11. W. ...
So. ...*

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.