

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-019497

STATE FILE NUMBER

2-4186

FILED MAY 18 1959

Registration District No.

Primary Registration District No.

Registrar's No.

300

1-57

26

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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 Saint Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION City Hospital # 1		Length of stay in lb -----	d. STREET ADDRESS 4257 Forest Park Blvd.
3. NAME OF DECEASED (Type or print) First MARGARET Middle LILLIAN Last O'NEILL			4. DATE OF DEATH April 27th, 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 Nov. 28, 1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Waitress		10b. KIND OF BUSINESS OR INDUSTRY Hospital	9. AGE (In years last birthday) 77
11. BIRTHPLACE (City and state or country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? USA	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
13a. FATHER'S NAME James O'Neill		13b. MOTHER'S MAIDEN NAME Alice Booth	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. 500-34-9037	17. INFORMANT Address Mrs. Jenny Luehrmann, 3719 N. Taylor Ave., 15,
18. CAUSE OF DEATH (Enter only one cause for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carotid Arteriosclerosis DUE TO (b) Generalized Arteriosclerosis DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
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.) 420.1	
20c. TIME OF INJURY Hour a.m. p.m.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Joseph S. [Signature]</i>		22b. ADDRESS 1300 Clark	22c. DATE SIGNED 4/29/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4/29/59	23c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Missouri
24. FUNERAL DIRECTOR ALVIN F. FEUTZ, 4828 Natural Bridge Blvd., St. Louis, 15, Missouri.		25. DATE RECD. BY LOCAL REG. APR 29 '59	26. REGISTRAR'S SIGNATURE Carl 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 *Ralph E. Linder*

Licensed Embalmer No. *42257*

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.