

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-030798

FILED VS AUG 27 1959

2 7444

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		c. CITY OR TOWN <u>St. Louis</u>	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3733 Lindell Blvd.</u>		d. STREET ADDRESS (If outside, give location) <u>3733 Lindell Blvd.</u>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>SATINA</u> Middle <u>SLATTERY</u> Last			4. DATE OF DEATH Month <u>August</u> Day <u>9</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11/10/91</u>	9. AGE (last birthday) <u>67</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Jacob carrigan</u>	13b. MOTHER'S MAIDEN NAME <u>Theresa ?</u>	14. NAME OF HUSBAND OR WIFE <u>Michael J. Slattery</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)	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Michael J. Slattery</u>	Address <u>3733 Lindell</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		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<u>Coronary Atherosclerosis</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	<u>Arterio Sclerotic Ht Dis</u>	
DUE TO (b)	<u>Arterio Sclerotic gen.</u>	
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

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.	Month, Day, Year
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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
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21. I attended the deceased from May 1959 to 8/6/59 and last saw her/him alive on 8/6/59.  
Death occurred at 819/590 3:30A m on the date stated above, and to the best of my knowledge, from the causes stated.

21a. SIGNATURE <u>Charles Krome M.D.</u>	(Degree or title)	21b. ADDRESS <u>1755 S. Grand</u>	21c. DATE SIGNED <u>8/10/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8/12/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Peter &amp; Paul Cem</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u>

24. FUNERAL DIRECTOR <u>CHULICK UND. CO.</u>	ADDRESS <u>1722 S. Jefferson</u>	25. DATE RECD. BY LOCAL REG. <u>AUG 11 '59</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>
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DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*V. E. Morris*

Licensed Embalmer No.

*3360*

P. O. Address

*St Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.