

FRI. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-007761

FILED VS MAR 8 1960

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 58

STATE FILE NUMBER

3/30/60 rms
3/30/60 rms
Morris Byrne
Hanora Griffin
DOCUMENT
MEDICAL CERTIFICATION
Morris O'Conner
Hanora Griffin
BY AFFIDAVIT OF Informant

1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>				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. CHARLES Charles</u>		Length of stay in 1b		c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph's Home</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>2540 E. University</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle <u>Byrne</u> Last				4. DATE OF DEATH Month <u>Feb</u> Day <u>28</u> Year <u>1960</u>				
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</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>4/20/1866</u>	9. AGE (last birthday) <u>93</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR 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 <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>		
13a. FATHER'S NAME <u>O'Conner</u>			13b. MOTHER'S MAIDEN NAME <u>Griffin</u>		14. NAME OF HUSBAND OR WIFE <u>John P. Byrne</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Mr. John Byrne 2540 E. University</u>				
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>Bronchial Pneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Demerol</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) <u>Arteriosclerosis</u>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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.)				
20c. TIME OF INJURY Hour Month, Day, Year 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 <u>Feb 24, 1960</u> to <u>Feb 28, 1960</u> last saw her/him alive on <u>Feb 24, 1960</u> Death occurred at <u>430 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>John P. Byrne</u> (Degree or title) <u>no</u>				22b. ADDRESS <u>1125 Main; St Charles Mo</u>		22c. DATE SIGNED <u>Feb 28, 1960</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>3/3/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		23d. LOCATION (City, town, or county) <u>St. Louis Mo.</u>		(State)		
24. FUNERAL DIRECTOR <u>Robert D. Kinealy 2228 St. Louis Ave.</u>				25. DATE RECD. BY LOCAL REG. <u>3/1/60</u>	26. REGISTRAR'S SIGNATURE <u>Marcella Wilson</u>			

VS MAR 30 1960

MAR 17 1960

STATEMENT BY LICENSED EMBALMER

MAR 29 1960

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 _____

Justus W. [Signature]

Licensed Embalmer No. 432

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.