

# MORTUARY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**FILED VS FEB 18 1960**

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 1500** STATE FILE NUMBER **60-008693**

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, MO</b>			Length of stay in 1b <b>Life</b>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSP. #1.</b>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>3427 Washington Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>C.</b> Last <b>CHEARN</b>				4. DATE OF DEATH Month <b>FEB.</b> Day <b>8,</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>12-25-1880</b>	9. AGE (last birthday) <b>79</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sales</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>John K. O'Hearn</b>			13b. MOTHER'S MAIDEN NAME <b>Johanna Pearce</b>		14. NAME OF HUSBAND OR WIFE <b>U.K. Reid (Deceased)</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>493-10-4151</b>		17. INFORMANT Address (20) <b>Mr. John J. Kinsella # 20 Oleander Dr</b>		
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) <b>Acute Pulmonary Edema</b>							<b>36 hrs.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							
DUE TO (b) <b>Acute Myocardial Infarction</b>							<b>36 hrs.</b>
DUE TO (c) <b>4201</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Acute Cerebrovascular Accident.</b>					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.)			
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year					
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 <b>2/7/60 11A</b> to <b>2/8/60</b> and last saw her/him alive on <b>2/8/60</b> Death occurred at <b>2P.M</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Daniel J. Hellman MD</b>				22b. ADDRESS <b>1515 LAFAYETTE AVE</b>		22c. DATE SIGNED <b>2/8/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2-10-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Arthur J. Donnelly 840 Lindell Blvd.</b>				25. DATE RECD. BY LOCAL REG. <b>FEB 9 1960</b>		26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*S.P.*

**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 James Miller

Licensed Embalmer No. 356  
P. O. Address 3840 2

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.