

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. JUN 29 1960

318

Primary Registration District No. 1003

Registrar's No.

5743-60-024550 STATE FILE NUMBER

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>St. Louis</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>48 Hrs.</b>		c. CITY OR TOWN <b>Clayton, Mo.</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Luke's Hospital</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>6425 Clayton Rd.</b>			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>MARGUERITE</b> Middle <b>HACKENYOS</b> Last				4. DATE OF DEATH Month <b>June</b> Day <b>2</b> Year <b>1960.</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W.</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>July 18, 1892</b>	9. AGE (last birthday) <b>67</b>	IF UNDER 1 YEAR Months <b>10</b> Days <b>14</b>	IF UNDER 24 HR Hours <b>48</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>Patrick J. Eagen</b>			13b. MOTHER'S MAIDEN NAME <b>Fannie Nugent</b>			14. NAME OF HUSBAND OR WIFE <b>August Hackenyos</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>August Hackenyos 6425 Clayton Rd.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized peritonitis (Gas bacillus)</b>						INTERVAL BETWEEN ONSET AND DEATH <b>48 hours</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Ruptured duodenal ulcer</b>						<b>48 hours</b>	
DUE TO (c) <b>Surgery for 541-0</b>						<b>36 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Cholelithiasis - Pseudo-Haemorrhoid - Colonic polyps and diverticula</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 checked="" type="checkbox"/> NO <input 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 <b>1:00</b> Month, Day, Year <b>April 1949</b>		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>April 1949</b> to <b>June 2 1960</b> and last saw her <b>alive</b> on <b>June 2, 1960</b> Death occurred at <b>1:00 P.</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>M. H. O'Leary</b> (Degree or title)				22b. ADDRESS <b>864 Hamilton Blvd St. Louis 12 Mo</b>		22c. DATE SIGNED <b>6-3-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>June 6, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>		
24. FUNERAL DIRECTOR <b>A. H. Bocklage F.H. 6536 Clayton Rd.</b> ADDRESS				25. DATE RECD. BY LOCAL REG. <b>JUN 4 1960</b>		REGISTRAR'S SIGNATURE <b>Koan Smith. M.D.</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Acc.

**STATEMENT BY LICENSED EMBALMER**

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

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

Signed Edward R. Padon

Licensed Embalmer No. 407

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.