

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-037006

FILED VS. **OCT 1 0 1960**

Registration District No. **317** Primary Registration District No. **590** Registrar's No. **2867** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY St. Louis,		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN Valley Park		Length of stay in lb DAYS	c. CITY OR TOWN Glendale, Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Moll Nursing Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 831 Alexander Dr. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First OWEN Middle O'HAGAN Last O'HAGAN			4. DATE OF DEATH Month Sept. Day 29th, Year 1960				
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7/12/1885	9. AGE (last birthday) 75	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) Plumber Laborer Retired		10b. KIND OF BUSINESS OR INDUSTRY Ryfel & Ratz		11. BIRTHPLACE (City and state or country) Ireland		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME			13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE Late Jane O'Hagen		

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.	17. INFORMANT James O'Hagan 831 Alexander Dr.
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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: IMMEDIATE CAUSE (a) Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)		
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 type="checkbox"/> No <input type="checkbox"/> Unknown		
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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
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21. I attended the deceased from **Sept 19, 1960** to **Sept 29, 1960** and last saw her alive on **Sept 25, 1960**
Death occurred at **12:30 A.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Robert J. Sanders, M.D. (Degree or title)	22b. ADDRESS 1502 Cass Av	22c. DATE SIGNED 9/30/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Oct. 1, 1960	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) St. Louis,	(State) Mo.
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24. FUNERAL DIRECTOR Kriegshauser-4228 S.Kingshighway Blvd	25. DATE RECD. BY LOCAL REG. 9-29-60	26. REGISTRAR'S SIGNATURE John C. Murphy M.D.
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DOCUMENT

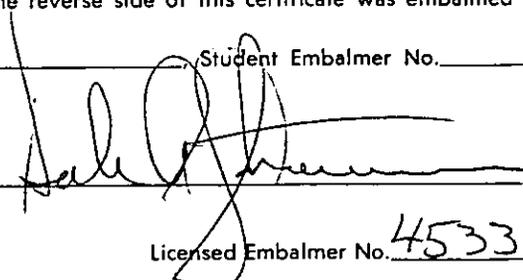
MEDICAL CERTIFICATION

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  _____

Licensed Embalmer No. 4533

P. O. Address _____

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