

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-044618

FILED VS DEC 12 1960

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 3516

INDEXED

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 Richmond Heights	Length of stay in 1b 1 YR 4 mon.	c. CITY OR TOWN Richmond Heights	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT IN hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS 1224 Arch terrace (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First WILLIAM Middle FRANCIS Last WHALEN			4. DATE OF DEATH Month Dec. Day 2, Year 1960.		
------------------------------------------------------------------------------------------------------	--	--	-----------------------------------------------------------------------	--	--

5. SEX M	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH July 10, 1959	9. AGE (last birthday) 1	IF UNDER 1 YEAR Months 4 Days	IF UNDER 24 HR Hours Min.
-----------------	---------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------	---------------------------------	-----------------------------------------	------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.
--------------------------------------------------------------------------------------------------------------	-----------------------------------	---------------------------------------------------------------------	----------------------------------------------

13a. FATHER'S NAME Michael Whalen	13b. MOTHER'S MAIDEN NAME Theresa Cunningham	14. NAME OF HUSBAND OR WIFE -----
---------------------------------------------	--------------------------------------------------------	--------------------------------------

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. None	17. INFORMANT Address Michael Whalen 1224 Arch Terrace
-----------------------------------------------------------------------------------------------------------------------	----------------------------------------	------------------------------------------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia due to drowning		INTERVAL BETWEEN ONSET AND DEATH
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
-----------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) Drowned in bath-tub
---------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------

20c. TIME OF INJURY 4:15 approx	Hour 6:00 p.m.	Month, Day, Year 12/2/60
-------------------------------------------	-----------------------	------------------------------------

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) bathroom of home	20f. CITY, TOWN, OR LOCATION COUNTY STATE Richmond Heights, St. Louis, Missouri
-------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------

21. I attended the deceased from _____, to _____ and last saw her/him alive on _____
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Raymond M. Harris</i> Coroner	22b. ADDRESS Clayton, Mo.	22c. DATE SIGNED 12/7/60
----------------------------------------------------------------------	-------------------------------------	------------------------------------

23a. BURIAL, CREMATION OR REMOVAL (Specify) REMOVAL	23b. DATE Dec. 5, 1960	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, a Mo.
---------------------------------------------------------------	----------------------------------	---------------------------------------------------------------	--------------------------------------------------------------------------

24. FUNERAL DIRECTOR A.H. Bocklage	ADDRESS F.H. 6536 Clayton Rd.	25. DATE RECD. BY LOCAL REG. 12-3-60	26. REGISTRAR'S SIGNATURE <i>J. B. Murphy M.D.</i>
----------------------------------------------	-----------------------------------------	------------------------------------------------	-------------------------------------------------------

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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Not Embalmed¹⁴⁸
W.H. Bock

Licensed Embalmer No. _____

P. O. Address _____

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.