

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-044719

ED VS DEC 12 1960

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3515 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lemay</u>		Length of stay in 1b <u>WKS.</u>	c. CITY OR TOWN <u>Pagedale</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mt. St. Rose Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>7345 Park Dr.</u>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>J.</u> Last <u>Haley</u>	4. DATE OF DEATH Month <u>Dec.</u> Day <u>2</u> Year <u>1960</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</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>7/2/92</u>	9. AGE (last birthday) <u>68</u>	IF UNDER 1 YEAR Months <u>5</u> Days _____ Hours _____ Min. _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pipewriter</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Carrier Corp. Air Cond.</u>	11. BIRTHPLACE (City and state or country) <u>Quincy, Ill.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Michael J. Haley</u>	13b. MOTHER'S MAIDEN NAME <u>Jennie Costello</u>	14. NAME OF HUSBAND OR WIFE <u>Edith</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes World War I</u>	16. SOCIAL SECURITY NO. <u>492-09-8857</u>	17. INFORMANT Address <u>Mrs. Jennie H. Hughes 7345 Park Dr.</u>
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<u>Cerebrovascular Thrombosis</u>	<u>1 Week</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arteriosclerosis, General</u>	<u>20 yrs</u>
	DUE TO (c) <u>Hypertensive Cardio Vascular Disease</u>	<u>20 yrs</u>

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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year _____
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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 <u>St. Louis</u>	COUNTY <u>St. Louis</u>	STATE <u>Mo.</u>
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21. I attended the deceased from 10-14-60 to 12-2-60 and last saw him alive on 12-2-60
Death occurred at 11:30 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Paul Murphy M.D.</u> (Degree or title)	22b. ADDRESS <u>508 N Grand</u>	22c. DATE SIGNED <u>12-3-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12/5/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>
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24. FUNERAL DIRECTOR <u>Chas. F. Stuart</u> ADDRESS <u>1225 Union Bl.</u>	25. DATE RECD. BY LOCAL REG. <u>12-4-60</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>
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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 Harry E. Monroe

Licensed Embalmer No. 4995

P. O. Address St. Louis, Mo.

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