

AMENDED

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DePaul Hospt.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4311 N. 19th St.
3. NAME OF DECEASED (Type or print) First Middle Last Mary Anna Cleary			4. DATE OF DEATH Month Day Year 1 30 61
5. SEX F	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6/21/88
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	9. AGE (last birthday) 72
11a. FATHER'S NAME August Witzig		11b. MOTHER'S MAIDEN NAME Mary Mutter	11c. NAME OF HUSBAND OR WIFE James Cleary
12. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		13. INFORMANT Address Rose Hanstein 2512 W. Sullivan	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Labar pneumonia</i> DUE TO (b) _____ DUE TO (c) _____ 490X Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 3 wks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART (a) <i>Arteriosclerotic heart disease</i>			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 <i>1-9-61</i> to <i>1-30-61</i> and last saw her/him live on <i>1-29-61</i> . Death occurred at <i>10 A.M.</i> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>St. J. Feller</i> (Degree or title) MD		22b. ADDRESS <i>St. Louis Mo</i>	22c. DATE SIGNED <i>1-31-61</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2/1/61	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis MO.
24. FUNERAL DIRECTOR ADDRESS Robert D. Kinealy 2228 St. Louis Ave.		25. DATE RECD. BY LOCAL REG. JAN 31 1961	26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i>

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 *Herbert J. Lan Jr.*

Licensed Embalmer No. 4800

P. O. Address Kirkwood 22

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.