

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3005 STATE FILE NUMBER 61-011615

FILED APR 14 1961

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>			Length of stay in 1b		c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2647 Accomac</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>2647 Accomac</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle <u>Agnes</u> Last <u>Stair</u>				4. DATE OF DEATH Month <u>March</u> Day <u>29</u> Year <u>1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 31, 81</u>	9. AGE (last birthday) <u>79</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and state or country) <u>DeSoto Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Patrick Flynn</u>			13b. MOTHER'S MAIDEN NAME <u>Honora Kaine</u>			14. NAME OF HUSBAND OR WIFE <u>Logan J. Stair</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Logan J. Stair 2647 Accomac</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary occlusion</u> <u>Coronary occlusion</u> DUE TO (b) <u>arteriosclerosis, general</u> <u>arteriosclerosis general</u> DUE TO (c) <u>420.1</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</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) <u>diabetes mellitus</u> <u>diabetes mellitus</u>					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 Month, Day, Year a.m. p.m.							
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 <u>October 1, 1957</u> to <u>March 29, 1961</u> and last saw her ^{her} alive on <u>March 7, 1961</u> Death occurred at <u>9:15 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>J.W. Noah</u> (Degree or title) <u>Joseph W. Noah MD</u>				22b. ADDRESS <u>100 N. Euclid</u>		22c. DATE SIGNED <u>3/29/61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>Apr 3, 61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SunSet Burial Park</u>		23d. LOCATION (City, town, or county) <u>St. Louis Cty Mo.</u>		
24. FUNERAL DIRECTOR <u>E.J. Schnur 3125 Lafayette</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>MAR 30 1961</u>		26. REGISTRAR'S SIGNATURE <u>Loard Smith, M.D.</u>	

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

ITEM NO.

Faint, mostly illegible text at the top of the page, possibly containing names and dates.

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 *Thomas R. Tenwick*

Licensed Embalmer No. 3793

P. O. Address 3125 Lafayette

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.