

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-027332

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7248 STATE FILE NUMBER

FILED AUG 14 1961

DATE AMENDED

INSTEAD OF

DOCUMENT

SHOULD READ

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY		c. CITY OR TOWN		Inside Limits		
		St. Louis		Over 20 yrs		Missouri				St. Louis		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION				Inside Limits		d. STREET ADDRESS (If outside, give location)				Reside on Farm		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
St. Louis State Hospital				Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		5100 Arsenal								
3. NAME OF DECEASED (Type or print) First Middle Last						4. DATE OF DEATH Month Day Year								
Elizabeth Shannahan						August 2, 1961								
5. SEX		6. COLOR OR RACE		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HR		
Female		White				11/16/04		56		Months Days		Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country)			12. CITIZEN OF WHAT COUNTRY					
Office work						St. Louis, Mo/			U.S.					
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE						
John Shannahan				Anna Barrett				NONE						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address								
NO				NONE		John Stanton 2917 Ralph Street Granite City, Ill.								
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) Congestive Heart Failure														
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Acute Interstitial Myocarditis														
DUE TO (c) 431X														
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.				
Pneumonitis -Interstitial										<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <u>April 21, 1961</u> to <u>August 2, 1961</u> and last saw her/him alive on <u>August 2, 1961</u> Death occurred at <u>12:30</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.														
22a. SIGNATURE (In printer's type) <i>Richard T. Purck, M.D.</i>						22b. ADDRESS 5100 Arsenal St.				22c. DATE SIGNED 8/2/61				
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town, or county)			(State)			
REMOVAL		8-2-1961		CALVARY				St. Louis, Mo.						
24. FUNERAL DIRECTOR <i>Frank Mercer</i>				ADDRESS GRANITE CITY,				25. DATE RECD. BY LOCAL REG. AUG 4 1961		26. REGISTRAR'S SIGNATURE <i>Loal 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 Charles E. Mercer

Licensed Embalmer No. 2988

P. O. Address Granite City

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.