

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH -61-038370

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **9474** STATE FILE NUMBER

AMENDED FILED OCT 26 1961

1. PLACE OF DEATH a. COUNTY		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 St. Louis		Length of stay in lb Life	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. John's Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 7349 Hoover Ave. Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Eugene Middle T. Last Byrne	4. DATE OF DEATH Month October Day 11th. Year 1961
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5. SEX M.	6. COLOR OR RACE W.	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9/17/1882	9. AGE (last birthday) 79	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during last week, including retired) Bank Clerk - Retired	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY U.S.
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13a. FATHER'S NAME John Byrne	13b. MOTHER'S MAIDEN NAME Maria O'Neill	14. NAME OF HUSBAND OR WIFE Mrs. Amelia Byrne
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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) no	17. INFORMANT Address Mrs. Amelia Byrne, 7349 Hoover Ave., R.H.
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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: IMMEDIATE CAUSE (a) Carcinoma of the head of the parotid		INTERVAL BETWEEN ONSET AND DEATH about 2 wks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	157X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Exploratory Laparotomy 10-30-1961	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 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.)
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20c. TIME OF INJURY Hour 2:00 a.m. p.m.	Month, Day, Year 9-15-61
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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 St. Louis, Missouri	COUNTY St. Louis	STATE Missouri
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21. I attended the deceased from **9-15-61** to **10-11-61** and last saw her alive on **10-10-61**
Death occurred at **2:00 a.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Arthur K. Oriskany M.D.	(Degree or title)	22b. ADDRESS 7570 Desmarline, St. Louis 19	22c. DATE SIGNED 10-12-61
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10/14/1961	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) St. Louis, Missouri	(State)
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24. FUNERAL DIRECTOR Arthur J. Donnelly	ADDRESS 3840 Lindell Blvd.	25. DATE RECD. BY LOCAL REG. OCT 13 1961	26. REGISTRAR'S SIGNATURE Loard Smith. M.D.
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DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
SHOULD READ
BY AFFIDAVIT OF
ITEM NO.

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  _____

Licensed Embalmer No. 4699

P. O. Address 3840 Lindell

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.